NO. 44613-8-II

COURT OF APPEALS
FOR THE STATE OF WASHINGTON
DIVISION II

Auburn Regional Medical Center,

Appellant,

v.

Department of Social and Health Services,

Respondent.

APPELLANT'S OPENING BRIEF

Carla M. DewBerry, Bar# 15746
GARVEY SCHUBERT BARER
Attorneys for Appellant

Eighteenth Floor
1191 Second Avenue
Seattle, Washington 98101-2939
206 464 3939

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I.

INTRODUCTION

Petitioner, Auburn Regional Medical Center ("the Hospital") is a 149-bed general hospital located in Auburn, Washington. (A.R. 465.[1]) The Hospital has a contract with Respondent, the Department of Social and Health Services (the "Department"), to provide services to Medicaid recipients. *Id.* The Department audited Medicaid payments to the Hospital and determined that the Hospital had been overpaid. (A.R. 467.) The audit examined "overpayment[s] for accounts with unapplied . . . spend down." *Id.* The audit covered services provided from January 1, 1999 through May 31, 2005. *Id.*

The audit found net overpayments under the Medicaid program in the amount of $85,649.84, plus interest through March 31, 2006, of $32,923.39. (A.R. 467.) The audit assessment was dated April 10, 2006. (A.R. 467.) The Hospital appealed the April 10, 2006 overpayment assessment and audit report. That appeal was assigned to Administrative Law Judge Mauer. Judge Mauer conducted a hearing on March 27, 2007 and held that "the April 10, 2006 vendor overpayment claim may not be enforced." (A.R. 2122.)

Thereafter, on May 10, 2007 the Department re-mailed the original December 2005 audit report to the Hospital a second time with a letter

[1] A copy of the adjudicative record and transcript from the administrative hearing is included in the record here before the Court. It was certified to this Court by the Department of Social and Health Services. We refer in this Brief to the Certified Copy of the Original Agency Record for Judicial Review as the AR followed by the page number assigned to that document in that record.

stating that the Department had overpaid the Hospital $85,649.84 (fully repaid prior to the May 10, 2007 letter), which giving credit for prior payments left a balance (unpaid interest) of $32,923.39, plus additional interest to be calculated (the "Second Assessment"). (A.R. 468.) (The $85,649.84 amount was later reduced to $75,971.84. (A.R. 62.))

The Hospital appealed the assessment a second time; that appeal was heard by Judge Radcliffe and ultimately adjudicated by the Board of Appeals. The Board of Appeals issued a Review Decision and Final Order dated June 28, 2012 (the "Second Final Order"), which found that the Hospital had been overpaid $75,971.84. (A.R. 62.)

Before either the First or Second Orders were issued the parties were involved in litigation in Thurston County which decided the question of how payments to Auburn should be calculated. The Court decided that the Department is required to use the formulas set out in WAC 388-550 to calculate payments to the hospital; those formulas do not allow for any deductions from the amount determined by applying the formula. ("[T]here was no legislative authorization to reduce the scheduled supplemental Medicaid payment once a person met the definition of 'medically indigent.' To the extent the Department's polices or regulations so provided, they were inconsistent with the statute and invalid."[2] A.R.

[2] *Capital Medical Center et al. v State DSHS*, Thurston County Cause No. 03-2-02540-0 was a suit brought by 26 hospitals, including Auburn Regional Medical Center, challenging the deduction of spend down and an amount known as EMER from payments due hospital under the Limited Casualty Program. The Limited Casualty Program includes both the Medically Indigent Program ("MI") (the subject of the Capital Medical Center case) and the Medically Needy Program (the subject of this litigation). *See* RCW 74.09.700 (2001).

2172.) In the audit, the Department proposed to deduct an amount known as spend down from the amounts calculated using the payment formulas.

II.

ASSIGNMENTS OF ERROR

The trial court erred by affirming the Board of Appeals determination that Auburn had been overpaid.

III.

STATEMENT OF THE CASE

At issue is whether the Department had the authority to reassert an overpayment assessment when the assessment was dismissed in a prior adjudicative proceeding.

A second question is whether the Department may pay Auburn an amount which is different from the payment calculated using the Medicaid payment formulas set out in WAC 388-550-3000 (for inpatient claims) and WAC 388-550-4500 (A.R. 936-1081) (referred to herein as the "Formula Payments").

Spend down under both subcomponents of the Limited Casualty Program (i.e. the MN Program and the MI Program) is provided for by one (and the same) provision of the RCW – RCW 74.09.700. A.R. 613. That section provided as follows with respect to all times at issue in this case – "medical care may be provided under the limited casualty program to persons not otherwise eligible for medical assistance or medical care services who are **medically needy** as defined in the social security Title XIX state plan and **medical indigents** in accordance with eligibility requirements established by the department. The eligibility requirements may include minimum levels of incurred medical expenses." *Id.* Emphasis added. The Department imposed as an eligibility requirement that patients must have incurred a minimum level of medical expenses. (*See* WAC 388-550-5100. A.R. 973-978) This minimum level is referred to as spend down.

An additional question is whether the Department can deduct spend down from the Formula Payments. The Department's audit asserts that the Formula Payments were incorrect and that an amount called "spend down" under the Medically Needy ("MN") program should have been deducted from payments to the Hospital. However, spend down is never deducted from payments to a hospital. (As stated above this issue has already been decided in the Hospital's favor by this Court. A.R. 2172.) Undisputed is that spend down represents patient medical bills which the patient must incur before (s)he could qualify for coverage by the MN program.

The final issue presented is whether the Department correctly calculated the spend down amount which it claims should be deducted from the Formula Payments. As is appropriate when the Superior Court upholds an administrative decision, in this case the Superior Court did not enter its own findings of fact concerning the amount of each spend down deduction. However, the Superior Court's review included a review of a spread sheet which lists each spend down amount deducted by the Department (*see* Exhibit A-21, A.R. 3994-4000) and a summary description of the deficiencies pertaining to the evidence used by the Department to determine the spend down amount for each claim at issue in the audit. *See* Appendix A, attached, which was an exhibit to the Appellant's trial brief before the Thurston County Judge.

IV.

LEGAL ANALYSIS

A. Res Judicata and Collateral Estoppel Bar the Overpayment Assessment

Both because the assessment was set aside in a prior administrative hearing and because the treatment of spend down as a deduction from hospital payments had been resolved in prior litigation, the Department lacked the authority to institute the process which led to the hearing now under appeal before this Court.

The proceeding before the Office of Administrative Hearings (the original administrative proceeding held to contest the audit findings) resulted in a ruling that "there is no enforceable final audit or . . . overpayment claim subject to administrative hearing." A.R. 2123.

The Department, however, then re-mailed the original audit report and the original assessment, accompanied with a Second Overpayment Notice, to the Petitioner in an attempt to resuscitate its claimed overpayment. (A.R. 468.) The Hospital appealed that action, and this lawsuit followed. Thus, the Department seeks to enforce in this proceeding the very same audit and assessment which was previously dismissed. There was only one audit and one overpayment assessment. (A.R. 468.) The Department cannot utilize a second letter transmitting the audit assessment to enforce claims which were dismissed in the prior proceeding.

The audit assessment was appealed and that appeal resulted in a determination on the merits. ("[A] dismissal with prejudice constitutes a final judgment on the merits." *Hisle v. Todd Pacific Shipyards Corp. 151 Wash.2d 853, 866, (2004).*) Although a "dismissal based on lack of standing" does not constitute a judgment on the merits (*Ullery v. Fulleton,* 162 Wash. App. 596, 605, (2011)), the proceeding before Judge Mauer was not dismissed for lack of standing. The Department's assessment was set aside because the assessment was not properly asserted by the Department. ("[T]he method of notification requirement . . . must be treated as a limitation on the state action so as to give effect to the object of obtaining a valid enforceable overpayment claim." A.R. 2129.)

Further, in litigation which preceded this dispute about the audit here at issue, the parties resolved the law as applied to how payments should be calculated. In that litigation, referred to as the Capital Medical Center litigation, the Department fully litigated the substantive issue of whether it could deduct spend down from hospital payments. The Court held that "the Department had no authority to deduct EMER or other amounts from DRG scheduled payments to hospitals that provided care to medically indigent patients." A.R. 2174.

The doctrines of res judicata and collateral estoppel prevent the Department from pursuing the spend down issue a third time because the spend down assessment was the subject of both a prior administrative process and prior litigation. The Department was precluded from re-asserting the overpayment assessment after it proceeded with the first

administrative hearing to enforce the assessment and after it litigated the spend down issue.

The Department's entitlement to one bite at the apple is inherent in the dispute resolution process which applies to Medicaid audits. The one-bite concept serves as a framework for the final adjudication of disputes with state agencies.

The dispute resolution process, as applied to Medicaid audits, starts with an agency audit, which is followed by the issuance of audit findings, then an informal dispute process, an administrative appeal, and finally, judicial review. WAC 388-502-0240(6) defines the Medicaid audit and appeal process as:

> (a) an examination of provider medical and financial records;
>
> (b) a draft audit report, which contains preliminary findings and recommendations;
>
> (c) a dispute conference, if the provider requests it;
>
> (d) a final audit report; and
>
> (e) the right to an administrative appeal.

Here there was one draft audit report, one dispute conference, and one final audit report. (A.R. 467.) The second mailing of an overpayment notice simply reasserts the Department's claims.

The doctrine of res judicata bars the Department's attempt to collect on the original audit assessment. Res judicata "bars a second action if that action has a 'concurrence of identity' with a prior judgment." *Snyder v. Munro*, 106 Wn.2d 380, 383, 721 P.2d 962 (1986) (quoting

Rains v. State, 100 Wn.2d 660, 663 (1983)). Here, there is total identity in the prior proceedings of: (1) subject matter – i.e., the deduction of spend down; (2) cause of action – i.e., appeal of a proposed deduction; (3) persons and parties – the Hospital and the Department; and (4) the quality of the persons for or against whom the claim is made – hospitals. Clearly, the doctrine of res judicata bars the Department's claims.

The doctrine of collateral estoppel also applies and bars the Department's assessment. Collateral estoppel "reflects our legal system's emphasis on finality." *State v. Vasquez, 109 Wn. App. 310, 312 (2001)* (citing *State v. Barnes,* 85 Wn. App. 638, 652-53 (1997).) The doctrine of collateral estoppel prevents a litigant from re-litigating "previously determined issues between the same parties, to promote judicial economy, and to prevent harassment of and inconvenience to litigants." *Malland v. State Dep't of Retirement Systems,* 103 Wn.2d 484, 489 (1985) (citing *State v. Dupard,* 93 Wn.2d 268 (1980)).

Where res judicata prevents a second assertion of the same claim or cause of action, collateral estoppel "prevents a second litigation of [the same] issues between the parties, even though a different claim or cause of action is asserted." *Alishio v. Dep't of Social & Health Services,* 122 Wn. App. 1, 5 (2004).

Both this overpayment assessment and the overall issue of deducting spend down have been litigated and resolved on the merits. The Department's claims should thus be set aside.

B. The Department's Findings Are Flawed.

Even if the claims were not barred, the claimed overpayment is wrong.

1. Medicaid Regulations Specify How The Hospital's Payments Are To Be Calculated.

Medicaid is a highly organized program, the requirements of which are well-defined by federal statutes and regulations as well as state statutes and regulations. Neither party has claimed that those statutes or regulations are ambiguous as to the required calculation of hospital payments. There is no ambiguity concerning the formula set out in the regulations which is required to be used to calculate Medicaid payments to the Hospital. WAC "388-502 specifies the terms of payments for state medical program beneficiaries." A.R. 2064. WAC 388-550 describes the method for calculating Medicaid hospital payments. (See A.R. 917-1081.) The regulations require the Hospital to be paid on a DRG basis (basically a flat fee) for inpatient care. *See* A.R. 1139. Auburn was paid on this basis. (See, the following examples: Patient Robert Jxxx assigned to DRG 142. A.R. 2270; Patient Sandra Sxxx assigned to DRG 122. A.R. 1977; Patient Orella Sxxx assigned to DRG 144.)

The DRG payment is calculated by "multiplying the hospital's specific conversion factor by the DRG relative weight for the client's medical diagnosis." A.R. 1139. Outpatient services are paid based on a fee schedule. See, A.R. 2061. There is no mention in the regulations of any deduction or offset from these Formula Payments. The deductions

proposed as audit findings were not based on miscalculation of the payments required by the formulas.

Despite the clarity of its payment requirements, the Department claims that it can, on audit, deduct spend down from payments. Spend down is a process which allows patients, who otherwise have excess resources, to qualify for Medicaid coverage under the MI and MN Programs – it is not an amount to be deducted from hospital payments. ("When a person has or will have 'excess income' they are not eligible for MN coverage until they have medical expenses which are equal in amount to that excess income. This is the process of meeting 'spend down." WAC 388-519-0100 (2005). A.R. 949.)

The term "spend down" may mislead a layperson into believing that a patient with excess income must actually spend money in order to enroll in the MN Program. This is not the case. A person meets his/her spend down obligation by producing bills for incurred medical expenses. When the bills presented equal the amount of the family unit's excess income, the patient is certified as a participant in the MN Program. ("Once a person's spend down amount is known, their qualifying medical expenses are subtracted from that spend down amount to determine the date of eligibility." WAC 388-519-0110(7) (2005), effective 9/1/98.) Medical expenses are to be deducted from income in a specific order. *See* WAC 388-519-0110.

Both the federal laws regulating the Limited Casualty Program (including the MN Program) and the Washington Medicaid regulations

clearly provided that spend down is a deduction from a patient's income; there is no authority to deduct spend down from payments to a hospital. However, in the audit, spend down was deducted from payments to the Hospital and the Department now claims that the Hospital had been overpaid (and therefore must re-pay the Department) $75,971.89 with respect to spend down. (A.R. 62.)

In response to these federal requirements, Washington State adopted a Medicaid state plan and adopted regulations which establish the rules applicable to the MN Program. The state plan and the regulations are consistent with federal law as to the fundamentals concerning spend down. However, as the Department readily conceded in the hearing, the Department largely ignored these requirements in practice and the auditor made no attempt to correct these errors in determining whether any overpayments had occurred.

For example, RCW 43.20B.675 premises Medicaid recoupment on a finding that a provider has been overpaid. However, here the auditor limited her work to the task of simply determining whether the spend down had been deducted from the Medicaid fee schedule amount payable to Auburn. She did not verify the amount of the spend down, how the patient met his/her spend down obligation, whether bills used to meet spend down were applied in the priority required by the regulations, when spend down was met, or the effective date of the patient's enrollment in the Medically Needy program. Thus, the audit did not purport to

determine if the Hospital had been overpaid; and as discussed below no overpayment was made.

2. The Department Mis-applied Spend Down

a. Spend Down Is Not a Deduction From Payments Owed the Hospital

The audit did not attempt to determine whether the Hospital had been overpaid. (An "overpayment" is defined as the "amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the [Social Security] act." *42 C.F.R. 433.304.*)

b. Spend Down Is Deducted from Patient Income Not Hospital Payments

The MN Program provides health care benefits to qualified individuals who have limited income and assets. If a patient's income is too high, the patient can qualify for medical coverage if the patient's unpaid medical bills meet a specific threshold; thereafter, the MN Program will cover any additional medical bills.

Spend down is a process by which medical bills incurred by a patient prior to the time he/she is eligible for medical coverage under the MN Program are used to reduce the patient's assets so that he/she can thereafter qualify for MN coverage. Federal Medicaid law (i.e., Sections 1092(a)(17) and 1903(f)(2) of the Social Security Act) provides that "for individuals applying as medically needy, certain incurred medical expenses must be deducted from income if income exceeds the eligibility standard established by the State." (*See* A.R. 2145, 59 Fed. Reg. 1659,

January 12, 1994.) Washington's regulations are consistent with this federal requirement. (If the person would otherwise qualify for MN coverage, but he/she has excess income, the individual "may become eligible for MN medical coverage when they have or expect to have medical expenses" which reduce income below the MNIL. WAC 388-519-0100(6). "Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL." WAC 388-519-0100(6).)

Further, Washington's MN regulations explain that "[w]hen a person has or will have 'excess income,' they are not eligible for MN coverage until they have medical expenses which are equal in amount to that excess income. This is the process of meeting 'spend down.'" WAC 388-519-0100(8). WAC 388-519-0110, which provides further details about "spend down of excess income for the medically needy program," provides:

> the amount of a person's 'spend down' is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL [medically needy income limit]. The excess income from each of the months in the base period is added together to determine the 'spend down' for the base period.

WAC 388-519-0110(5).

It is not contested that a patient's spend down requirement must be satisfied before the patient can be enrolled in the MN Program. ("If a person's spend down amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets

the spend down amount." WAC 388-519-0110 (9).) Nor is it disputed that services represented by bills used to meet a spend down obligation are not covered by Medicaid. However, the Department deducted spend down from payments with respect to services provided after a patient met spend down. As discussed below, this is a fundamental flaw in the assessment.

(1) Spend Down Is Not the Patient's Portion Of a Medicaid Allowed Charge

Bills used to meet a spend down obligation are **never** covered by the MN Program. ("Expenses used to meet spend down are not reimbursable under Medicaid. To the extent necessary to prevent transfer of an individual's spend down liability to the Medicaid program, States must reduce the amount of provider charges that would be otherwise reimbursed under Medicaid." *42 C.F.R. § 435.831(i)(5)).* Thus, there is no logic supporting the auditor's decision to deduct spend down from charges from covered services.

(2) Deducting Spend Down From Medicaid Payments Makes No Sense and Is Contrary To the Applicable Regulations

Deducting spend down from Medicaid payments is illogical for at least two other reasons. First, the Medicaid fee schedule and hospital charges are completely unrelated. It thus makes no sense to subtract hospital charges from the discounted Medicaid payment rate. (It does make sense to follow the federal regulation which instructs states, in appropriate circumstances, to deduct spend down from charges.[3]) Second,

[3] 42 C.F.R. § 435.831 provides that "expenses used to meet spend down liability are not reimbursable under Medicaid. To the extent necessary to prevent the transfer of an

deducting spend down from Medicaid payments ignores the existence of a Medicaid coverage period because the deduction treats pre-coverage expenses as bearing a direct relationship on payment for post-coverage services.

c. The Department Never Established that Services Provided By the Hospital Were Used By Patients To Meet a Spend Down Obligation

(1) The Audit Did Not Assess Whether Spenddown Was Properly Assigned To the Hospital

The scope of the audit was very limited and narrow. Ms. Spencer, the auditor, testified that she never assessed the correctness of the amount she treated as a patient's spend down obligation, nor did she confirm which medical bill was used by the patient to meet spend down. (Tr. I:132–33.[4])

At the hearing, Ms. Spencer testified about her methodology for conducting the audit. First, she pulled a report of all payments made to the Hospital relating to claims between January 1, 1999 and May 31, 2005 ("HWT Report"). (Tr. I:40:9–14.) This report came from a system called HWT. (*Id.*) HWT is a Department database which contains payment records. (*See* Tr. I:42:5–8.) In this case, the report contained 712 claims. Ms. Spencer, or somebody working with Ms. Spencer, then used ACES[5]

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individual's spend down liability to the Medicaid program, States must reduce the amount of provider *charges* that would otherwise be reimbursed under Medicaid" (emphasis added).

[4] We refer to the transcripts from the Administrative Hearing before Judge Radcliffe by volume and page number, i.e., TR I, II or III.

[5] ACES is the Department's "Automated Client Eligibility System." (Tr. III:93:22.)

to look up each patient, to see whether the ACES system reflected that a Department caseworker had made a note about spenddown and whether that note indicated whether the caseworker assigned spenddown to a medical service provided by the Hospital (i.e., to a Hospital bill) and whether the bill used to meet spenddown coincided with the dates of any of the 712 claims on the HWT report. (Tr. I:41:1–6). She testified that she had to look at multiple lines on the HWT spreadsheet to perform her audit. (Tr. II:154–55.)

If Ms. Spencer concluded that spenddown had been assigned to the Hospital for a date of service within the audit period, she then researched whether the hospital had "utilized that spenddown in their claimed billing to DSHS." (Tr. I:41:6–9.) She said that in her triangulation process, the "date of service is very vital." (Tr. I:65:25.)

It was not within Ms. Spencer's mandate to question whether spend down had been correctly or properly assigned by the caseworkers. (Tr. IV:86:8–22.) She did not double-check prioritization of bills although the regulations do have a priority in which bills are used to meet spenddown.[6] (Tr. IV:86:8–22.) She had no way to determine whether the CSO worker entered all bills that could have been used to meet spend down into ACES. If the information in ACES reflected that spend down had been assigned to a Hospital visit by a caseworker, Ms. Spencer simply assumed that the assignment was correct (Tr.

[6] *See also* Tr. II:69:22–24 (stating that she did not use expense type codes in any way during her audit).

IV:86:8–22), then proceeded to check whether the Hospital had reported the spend down.

(2) The Data Relied Upon By Ms. Spencer Is Fundamentally Unreliable

(a) ACES

Ms. Spencer testified that in her summary spreadsheet ("DSHS Summary Table") (A.R. 1191-1195), the information in the column called "SD/EMER assigned" was manually input by Ms. Spencer and was derived from information in the ACES system. (Tr. I:46:9–13.) Then, Ms. Spencer compared this amount to the total DSHS payment received by the Hospital for the incident of service at issue. If the total DSHS payment received was less than the amount in the "SD/EMER assigned" column, Ms. Spencer made an overpayment finding equal to the amount of the DSHS payment. If the DSHS payment amount was greater than the amount in the "SD/EMER assigned" column, Ms. Spencer made an overpayment finding equal to the amount in the "SD/EMER assigned" column.

Ms. Spencer testified that her calculations rely heavily on the information in the ACES system. (Tr. I:133:16-20, stating that her audit considers only whether spenddown was taken correctly, only with respect to what's in the ACES system.) She further conceded that if ACES has the wrong information, her calculations could be wrong, too. (Tr. I:133:21-24.)

The problem is that the ACES data is incomplete and ACES was never used by Department staff for the purpose of capturing accurate historical data about patient bills. Department witness Cathy Fisher acknowledged this. (*See* Tr. III:136:10-13.) Further, data in ACES frequently did not match with the data from other sources such as HWT or hospital account records. (Tr. I:58:24-59:18, answering "yes" to the question: "Were there times you found discrepancies between the amount billed by the hospital as shown by the HWT system and the expense amount as shown on the ACES printout?") Among the 72 overpayment claims, there are 30 claims for which the ACES expense amount and the HWT expense amounts do not match. *See* A.R. 321-328.

Ms. Fisher and Ms. Spencer both acknowledged that the ACES data is incomplete and this is not a reliable or accurate database. The objective of the ACES system, as indicated by its name ("Automated Client Eligibility System"), is not about data capture but about computing the date of client eligibility.

Ms. Fisher testified that CSO workers are not required to have paper documentation of medical expenses to enter those expenses into the ACES system, and that "quite often," workers will obtain medical expense information over the phone from the providers. (Tr. III:112:14-24.) She also confirmed that ACES data and HWT data frequently do not match. Ms. Fisher explained that sometimes the CSO worker inputting the information into the ACES system is presented with only interim charges, or information over the phone from a provider, which is not always

accurate. (Tr. III:113:13-23.) She also acknowledged that she knew that caseworkers were "essentially only . . . trying to gather enough bills to meet the required spenddown amount." (Tr. III:136:2-4.) She explained that "the whole goal of this program is to help the client become eligible for Medicaid to help them cover the bills that they need help paying for." (Tr.III:136:10-13.) She further acknowledged that incomplete or inaccurate entry of client medical expenses could result in applying spenddown to one provider which fairly should have been provided to a different provider. (Tr. III:137:24-138:4.) She confirmed that the prioritization of expenses has been a chronic problem and there have been multiple attempts to clarify and simplify the process. (Tr. III:156:21-157:15.)

Ms. Spencer, too, confirmed that when caseworkers enter bills into the ACES system, their objective is to meet spenddown, not to enter complete and comprehensive information about all of the potentially qualifying expenses. (Tr. I:96–97.)

But despite the eminently defensible policy reasons for the ACES data entry process, the result of that process is a database that cannot be used reliably for the purpose of assessing money judgments against providers. ACES was not designed to be a historical database with a complete and accurate historical record of expenses. It was designed to enroll clients into assistance programs. While it contains some information, that information is useful for enrollment purposes, but it is not suitable to act as the data repository for how specific patients could or

did meet their spenddown obligations. To serve that function, the Department staff would have needed, at a minimum, to enter all information they actually had and to do it with the goal of entering it accurately. While the Department offers up many stratagems for a work-around, the fact remains that the data is unreliable. The strategies themselves confirm the existence of the deficiencies and the unreliability of the ACES information.

Of additional concern is when ACES data is internally inconsistent. These inconsistencies are found, for example, when the total spenddown assigned, according to an ACES Client Medical Expenses ("CME") page, is not the same number as the total spenddown liability for the coverage period at issue (this figure appears on the ACES spenddown summary page). These numbers should be the same. Among the 72 alleged overpayments, 17 claims rely on data containing this fundamental internal inconsistency.

The sheer frequency of inaccuracies and the existence of internal inconsistencies amply demonstrate that the problems are systemic problems. As the Department itself acknowledged, these deficiencies are a result of a data entry process specifically geared *not to be accurate and comprehensive*. In sum, ACES is not a reliable source of information and cannot be used for the purpose to which it has been put in this audit. For this reason, the Hospital asks that the Court reject the audit findings *in toto* as unsupported by a preponderance of the evidence.

(b) Award Letters

Ms. Spencer testified at the hearing that she sometimes relied on award letters, letters sent by the Department to a patient and sometimes other parties to communicate information about coverage, to corroborate data from other sources. However, the award letters are even less reliable than the information in ACES. Testimony at the hearing explained that award letters contained some static text (like a template or form) that appeared in every letter, plus had some areas that permitted a caseworker to manually input free-form text. Many of the award letters in the record here *have no free-form text inputted.* But the free-form text was often where specific information about a patient's bills or the amount of spenddown should appear. Therefore a letter might say: "We used the following bills to meet your spend down:" and have no more details where details were clearly meant to follow. (*See*, A.R. 1730.)

Furthermore, the letters often misinformed letter recipients about vital details, like the period of coverage. For example, consider a patient named Lena F. According to ACES, this patient met her spend down with an expense incurred on April 4, 2002.[7] (A.R. 1387.) According to applicable WAC 388-519-0110(7) and the Department's witnesses, coverage begins only once spend down has been met. (Tr. I:49:24-25 (Ms. Spencer); Tr. III:101:14-18 (Ms. Fisher).) However, the award letter dated April 26, 2002, informing the patient she had qualified for medically

[7] Problems with this expense are discussed further below in the claim-by-claim detail in the record (A.R. 102-133), extracted and appended hereto as Appendix A.

needy benefits, states that her coverage period began on December 1, 2001, about four months before she had "met" her spend down obligation. (A.R. 1389.) This cannot be correct.

In sum, the award letters cannot be relied on as a source of data, particularly not for data sufficiently reliable to support an audit compliant with Government Auditing Standards.

d. The Department's Audit In This Case Did Not Adhere to the Department's Own Standards For Such Audits

The Department's Amended Final Audit Report (A.R. 2058) states that the audit in this case used "guidelines established by the Department of Health and Human Services (DHHS) for abuse detection and control, following standards established by the U.S. General Accountability Office in its publication 'Standards for Audit of Governmental Organizations, Programs, Activities and Functions'." *Id.* at 2060. The Government Auditing Standards (the "Auditing Standards") require auditors to base their findings on "sufficient, appropriate evidence. . . . The concept of sufficient, appropriate evidence is integral to an audit." A.R. 333.

In this case, Ms. Spencer attempted to use ACES, a data source which both she and Ms. Fisher acknowledged is not a complete record of how patients met their spend down obligation, for the very purpose of establishing how that obligation was met. Only after the audit was completed did the auditor review the records kept by the Department (which included copies of medical bills submitted by patients to document their satisfaction of a spend down requirement). This information was

available for a limited number of claims. Further, the auditor's own review of the few source documents available illustrated the limitations of using the ACES database to recreate the evidence required to show how patient spenddown was met. Ms. Spencer testified that:

> Q: So if there were medical bills that an individual who was seeking coverage under the Medically Needy program brought to the CSO [community services office] but for some reason those bills had not been entered into ACES online, you would not have that information during your audit?
>
> A: No.
>
> . . .

(Tr. IV:53:14–53:19.)

She also testified that:

> Q: And did you find that most of the bills that the caseworkers had entered into ACES were scanned in the bar code?
>
> A: No.
>
> Q: Did you find that a significant number of the bills that they looked at were scanned in the bar code?

A: I am trying to remember. Anything before 2004 was very sketchy.

Q: This audit largely covered a period prior to 2004?

A: Correct, as far back as 1999, January '99.

(Tr. IV:58:16-58:25.)

Relying on ACES as a record of how patient spend down could have been met and should be assigned to providers despite that it is an incomplete and unreliable database for these purposes, violated the Accounting Standards. The Accounting Standards clearly state that "evidence has limitations or uncertainties when the validity of reliability of the evidence has not been assessed or cannot be assessed. Limitations also include errors identified by the auditors in their testing. When the auditors identify limitations or uncertainties in evidence that is significant to their findings and conclusions, they should apply additional procedures as appropriate. Such procedures include . . . seeking independent, corroboration evidence from other sources." A.R. 339.

Here, because the Department did not maintain the bills submitted by patients, and because the data collection was in many instances incomplete, the Department lacked the necessary corroborating evidence. The ACES data is unreliable and thus does not support the recapture of

monies paid to the Hospital along with interest. For these reasons, the Hospital asks that the Court reject the audit findings *in toto* as unsupported by a preponderance of evidence sufficiently sound to meet the requirements of the Auditing Standards.

e. The Department Has No Evidence That the Spenddown Has Not Already Been Deducted

When the Department pays the Hospital, it provides written notification of the payment. This written notification is called a remittance advice ("RA"). The RA lists details about the claim being paid.

In this case, the auditor did not review the actual RAs. Instead, she assumed that the amount paid was correct full payment and that the payment amount was calculated before spend down was deducted. Her testimony was as follows:

> Q: During the audit, did you do any work to verify that the calculated payment amount prior to spend down had been calculated correctly by the Department?
>
> A: No, it was beyond my audit scope.
>
> Q: So kind of fundamental to your audit process was the assumption the credit amount was correct before spend down?
>
> A: Correct.

Q: And were you also assuming that spend down should be subtracted from the amount paid to the hospital?

A: Yes.

Q: And have you done any research to verify that that's a correct assumption?

A: No, I have not. . .

(Tr. IV: 85:12-86:1.)

However, without reviewing the Department's documents, which were used to report to Auburn, or recalculating the payment amounts, the auditor could not ascertain whether the spend down had been offset from the payment. Therefore, the auditor was wholly uninformed as to whether the payment amount was correct or whether spend down had already been deducted from the amount paid.

V.
CONCLUSION

For the reasons stated above, Auburn requests that the Court reject *in toto* the Department's overpayment findings or, in the alternative, reject the overpayment line items with strikethroughs in the spreadsheet which summarizes each claimed overpayment. (A.R. 321-328.)

DATED this 20th day of May, 2013.

GARVEY SCHUBERT BARER

By _____
Carla M. DewBerry, Bar # 15746

PROOF OF SERVICE

I, Kristin Heuser, certify under penalty of perjury under the laws of the State of Washington that I caused a true and correct copy of the foregoing Appellant's Opening Brief, to be served on May 20, 2013 on the party listed below in the manner shown:

Stephen S. Manning, AAG — **Via Legal Messenger**
Office of the Attorney General
Social and Health Services Division
7141 Cleanwater Drive S.W.
Olympia, WA 98504

Dated this 20th day of May, 2013.

Kristin Heuser

SEA_DOCS:1102597.2

Appendix A (Extract From A.R. 102-133)

In the event the Court is hesitant to reject the Department's overpayment findings wholesale for the systemic reasons discussed above, the Hospital requests that the Court reject specific overpayment findings as shown in the strikethroughs on the summary table in Appendix B (A.R. 322-328), for the reasons specified below.

(1) Sione A.

1. Claim 1, for Sione A., is documented in Ex. D-6 and A-18 pp. 00904–06. Ms. Spencer concluded that the Hospital had been overpaid $4,506.00. (Tr. I:56:2-24, I:57:16-25, citing to DSHS Summary Table, line 1.) This overpayment claim is not supported by the preponderance of the evidence.

The data Ms. Spencer relied upon in computing the alleged overpayment is fundamentally unreliable. The ACES summary sheet for this patient (Ex. A-18 DSHS0904) reflects that the total spenddown for the coverage period beginning July 2004 going through December 2004 was $5,556.00. (Tr. II:21:21–22:3.) But according to the ACES CME detail, the total spenddown for this patient was no more than $4,506.00. (Ex. D-6 at 7.) Where the ACES data is not even internally consistent, it cannot serve as reliable evidence on which to recover thousands of dollars from the Hospital.

Further, while the ACES summary sheet reflects that $11,282.32 of bills were entered for this coverage period, the ACES CME detail sheet in the record reflects only a single visit, the Hospital bill of $8,853.35. Without seeing information about the other $2,428.97 of expenses considered for the purposes of spenddown for this coverage period, there is no way to verify that the bills were properly prioritized and that spenddown was properly attributed to the Auburn bill. At the very most, the Department should be permitted to recover $2,077.03 from the Hospital, not the full $4,506.[1] Because discrepancies in the Department's evidence must be resolved in

[1] $4,506 - $2,428.97 = $2,077.03.

favor of the Hospital, the data supports at most a conclusion that total spenddown for the applicable period is $4,506. There is no evidence that the Hospital's bill should have been prioritized ahead of the $2,428.97 of missing expenses. Therefore, those expenses should be applied to meet spenddown first, and the Hospital bill should be applied last.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. Ms. Spencer affirmed that neither the medical ID cards and letters available to the patient and/or to the Hospital appearing in the record contained any information about the amount of spenddown. (Tr. II:11:24–12:25; II:13:22.) If there is such evidence, it is simply not in the record in this proceeding.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover any money for this claim, or, in the alternative, permit an assessment of no more than $2,077.03. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate. The Hospital points out that recovery of the full amount of the alleged "overpayment" results in a net payment to the Hospital of $811.67, less than ten percent of the original total charges.

(2) Michael A.

2. Claim 2, for Michael A., is documented in Ex. D-7 and A-18 pp. 0920–21. Ms. Spencer concluded that the Hospital had been overpaid $952.00. (Tr. I:58:1:14) and Exhibit D-7. This overpayment claim is not supported by the preponderance of the evidence.

The HWT data for this patient reflects a Hospital bill amount of $17,000.75. (Ex. A-20 at line B-13.) The ACES data reflects an expense of $1,700.75 (Ex. A-18, 0920–21.) Ms. Spencer acknowledged this discrepancy, but dismissed the notion that it was significant in any way, explaining that "In this particular instance, we felt it was a typing error of not putting a zero because they have an expense amount $1,700.75 and the actual bill charges was $17,000.75." (Tr. I:58:18–22.) But this kind of error calls into question the accuracy of other data input into the ACES system as well, such as the total spenddown amount for the coverage period at issue.

Unlike the bill amount for which Ms. Spencer had another source, there is no other source of information that permits Ms. Spencer or this Court to judge the reliability of the total spenddown amount. In this case as in many others, the data Ms. Spencer relied upon in computing the alleged overpayment are fundamentally unreliable. Furthermore, as discussed above, Ms. Spencer's assumptions are not reliable.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. If there is such evidence, it is simply not in the record in this proceeding.

(3) Roberto A.

3. Claim 3, for Roberto A., is documented in Ex. D-8 and A-18 pp. 0926–28. Ms. Spencer concluded that the Hospital had been overpaid $144.48. (Tr. I:60:19-61:10.) This overpayment claim is not supported by the preponderance of the evidence.

The information in the record about this claim is hopelessly confused. The HWT report (Ex. A-20 at line B-18) and the hospital records (Ex. D-8 at 2–4) reflect that the expense at issue was incurred for Roberto A. But the ACES information (Ex. D-8 at 6–8) appears to relate to Valentina M. and indeed reflects that there were "No Medical Expenses" for Roberto (Ex. D-8 at 7). The award letter in the record is addressed to Valentina M., but pertains to MN benefits for Roberto A. (Ex. D-8 at 9.) The coverage period reflected on the medical ID cards is 12/01/04 through 1/31/05 (Ex. D-8 at 1, 5), but the coverage period reflected in the ACES system (Ex. D-8 at 6, 7) and the award letter (dated 6/03/05) (Ex. D-8 at 9–10) is 12/01/2004 through 5/31/2005.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. The award letter does not specify either a spenddown amount or what bills would be used to meet spenddown. If there is such evidence, it is simply not in the record in this proceeding.

(4) Patricia B.

6. Claim 6, for Patricia B., is documented in Ex. D-10 and A-18 pp. 0936–38. Ms. Spencer concluded that the Hospital had been overpaid $354.11. (Tr. I:62:24-64:1.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $1,031.25, but since the Hospital had only been paid $354.11 for the service against which spenddown had been assessed, the Department seeks to recoup $354.11, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $1,031.25. This overpayment claim is not supported by the preponderance of the evidence.

There are inconsistencies in the data in the record about the proper amount of total spenddown applicable to the coverage period at issue. The ACES data reflects a total spenddown amount of $1,370.50. (Ex. A-18 at 0936.) However, the award letter sent to this patient shows that her total spenddown amount would be $1,336.50. (Ex. D-10 at 7.) The award letter is also confusing with respect to how spenddown would be satisfied. The letter specifies the Auburn bill, accounting for $1,031.25 of the spenddown, but specifies no other bills while also stating on the second page that this patient has $1,372.50 in prior medical expenses. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $354.11 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(5) Steven B.

8. Claim 8, for Steven B., is documented in Ex. D-12 and A-18 pp. 0970–72. Ms. Spencer concluded that the Hospital had been overpaid $352.96. (Tr. I:66:24-67:24.)

Ms. Spencer concluded that the spenddown attributable to the Hospital was $591.54, but since the Hospital had only been paid $352.96 for the service against which spenddown had been assessed, the Department seeks to recoup $352.96, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $729.25. This overpayment claim is not supported by the preponderance of the evidence.

Ms. Spencer's process in reaching her conclusion was arbitrary. The ACES CME detail for this patient assigned $729.25 in spenddown for this patient to the Hospital, then split a UW Physicians bill to satisfy the apparently remaining spenddown. (Ex. D-12 at 6.) But, inconsistent with this, an award letter to the patient informed him that spenddown assigned to the Hospital would be $591.54. (Ex. D-12 at 4.) In concluding in her audit that the spenddown attributable to the Hospital was $591.54, Ms. Spencer deviated from her normal procedure, which would be to treat the ACES information as the primary authority, and decided to give the information in the award letter more credence.

The problem with Ms. Spencer's deviation from her normal process was that it introduced inconsistency into the audit. Worse, this specific deviation meant that Ms. Spencer abandoned her normal reliance on ACES, an already unreliable source of information, in favor of an award letter, an even more unreliable source of information. (*See supra*, discussion of award letters.)

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $352.96 on this claim because the Department's own data on this patient is internally inconsistent and because Ms. Spencer arbitrarily abandoned her normal methodology. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(6) Christopher C.

10. Claim 10, for Christopher C., is documented in Ex. D-14 and A-18 pp. 1015–16. Ms. Spencer concluded that the Hospital had been overpaid $120.00. (Tr. I:68:20-69:11.)

Recovery of this amount results in a net payment to the Hospital of $9.06 for a service originally billed at $543.57. This overpayment claim is not supported by the preponderance of the evidence.

The ACES information reflects an expense amount of $352.82. (Ex. D-14 at 4.) However, other information on the record, and which Ms. Spencer says she used to support her conclusions, reflects an expense amount of $543.57. (*See* A-20 at line B-90; D-14 at 2–3.) In many other claims in this case, Ms. Spencer was able to show why a discrepancy between expense amounts was immaterial because it reflected that a professional fee on hospital billing records had not been billed to the Department under the same provider number, or how a lower number was reflected in the hospital records as an interim number. But in this case, when asked, Ms. Spencer confessed that she could not account for the difference between the expense amount listed in ACES and the expense amount that is reflected in other documents. (Tr. I:69:12–18.) It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

Further, it appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on January 24, 2000. (Ex. D-14 at 4.) According to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) But the medical ID issued on February 24, 2000 and the approval letter dated February 24, 2000, informing the patient he had qualified for medically needy benefits, state that his coverage period began on January 1, 2000, almost a month before he had met his spenddown obligation. (Ex. D-14 at 5.) While the letter cites an Auburn visit, it does not state that any portion of the visit would be used to meet spenddown. (Ex. D-14 at 5.) The letter states that the patient has a total liability of $120.00 on this bill, but does not explain the source of that liability. It is not clear how the Department might expect a

patient to deduce from this cryptic letter that the $120.00 was a spenddown liability and that the Hospital should be so informed.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $120.00 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(7) Caralyn D.

14. Claim 14, for Caralyn D., is documented in Ex. D-18 and A-18 pp. 1049–57. Ms. Spencer concluded that the Hospital had been overpaid $311.87. (Tr. I:75:13-765.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $507.20, but since the Hospital had only been paid $311.87 for the service against which spenddown had been assessed, the Department seeks to recoup $311.87, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $1,379.95. This overpayment claim is not supported by the preponderance of the evidence.

The ACES CME detail reflects an Auburn expense amount of $507.20 used for spenddown. (Ex. D-18 at 3.) However, other information on the record, and which Ms. Spencer says she used to support her conclusions, reflects an expense amount of $1,379.95. (*See* A-20 at line B-129; D-18 at 2.) In many other claims in this case, Ms. Spencer was able to show why a discrepancy between expense amounts was immaterial because it reflected that a professional fee on hospital billing records had not been billed to the Department under the same provider number, or how a lower number was reflected in the hospital records as an interim number. But in this case, Ms. Spencer did not account for the difference between the expense amount listed in ACES and the expense amount that is reflected in other documents. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to

assess an overpayment against the Hospital. Therefore, the Hospital respectfully requests that this Court reject the Department's attempt to recover $311.87 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(8) Rudolph E.

16. Claim 16, for Rudolph E., is documented in Ex. D-20 and A-18 pp. 1091–92. Ms. Spencer concluded that the Hospital had been overpaid $1,722.00. (Tr. I:77:13-78:5.) This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary printout reflects a total spenddown amount for the period June 2001 through November 2001 of $1,718.00. (Ex. A-18 at 1091.) But the ACES CME detail assigns $1,722.00 of spenddown to an Auburn expense of $5,000 incurred on June 5, 2001. (Ex. D-20 at 6.) But there is no record of an Auburn expense of $5,000 incurred on June 5, 2001. Instead, the other documentation in the record reflects an expense of $4,342.00 incurred for a hospital stay from June 2–6, 2001. Adding to the confusion is a notation in the ACES narrative which says "Client was admitted to Auburn Regional Med Ctr 5/27/01–6/5/01 and incurred $5,000 of medical bills." (Ex. D-20 at 10.) These dates of service do not match at all.

Taking all this disparate information together to make her finding, Ms. Spencer had to make a guess about several things: (1) the correct amount of spenddown (she opted for the higher amount for no reason apparent from the record); (2) the date of service (was there another, separate service that began on May 27, 2001?); (3) the amount of the expense; and (4) the provider (could the May 27, 2001 service have been a service provided by another provider?). It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

(9) Patsy E.

17. Claim 17, for Patsy E., is documented in Ex. D-21 and A-18 pp. 1093–1103. Ms. Spencer concluded that the Hospital had been overpaid $236.39. (Tr. I:78:6-79:8.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $952.55, but since the Hospital had only been paid $236.39 for the service against which spenddown had been assessed, the Department seeks to recoup $236.39, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $952.55. This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary reflects a total spenddown liability for the period August 2004 through January 2005 of $3,769.00. (Ex. A-18 at 1098.) But the ACES CME detail sheet reflects that $3,744 in expenses was assigned to spenddown (Ex. D-21 at 4–5). These are conflicting total spenddown amount calculations and fundamentally affect the amount of spenddown assignable to providers.

The ACES CME detail sheet lists three apparent Auburn expenses:

8/11/2004 $1,055.00

8/31/2004 $952.55

8/11/2004 $32.00

Of these three, only the 8/31/04 charge is reflected in the Department's HWT system and has corresponding account records in the record in this proceeding. According to Ms. Spencer, there are no bills associated with either the $1,055 or the $32.00 expense. (Tr. II:147.) But if this is so, there is no way to verify whether the caseworker's entry of information about these expenses is complete or accurate.

On the contrary, the evidence in the records demonstrates that the caseworker entry of information is verifiably *in*accurate. For example, the Auburn expense of $1,055 appears as "paid" on the ACES CME detail sheet for this coverage period. But when this expense is improperly used again to meet spenddown for a later coverage period (since WAC 388-519-

0110(10)(a) doesn't allow the same expense to be used more than once to meet spenddown), it is coded as "unpaid." (Ex. D-22 at 5.)

Further, the approval letter generated for this patient for this coverage period stated that she would receive coverage beginning August 25, 2004. (Ex. D-21 at 6.) But according to the ACES CME detail sheet, her latest-in-time spenddown expense was the August 31, 2004 Auburn visit. If she had qualified on August 25, 2004, should not the August 31, 2004 Auburn visit have been paid by the Department without regard to spenddown?

It would be unreasonable to overlook these inconsistencies and the uncertainty regarding a foundational piece of data in Ms. Spencer's calculation, to conclude that the preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital. In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $236.39 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(10) Patsy E.

18. Claim 18, also for Patsy E., is documented in Ex. D-22 and A-18 pp. 1093–1103. Ms. Spencer concluded that the Hospital had been overpaid $652.97. (Tr. I:79:9-23.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $1,958.30, but since the Hospital had only been paid $652.97 for the service against which spenddown had been assessed, the Department seeks to recoup $652.97, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $2.747.13. This overpayment claim is not supported by the preponderance of the evidence.

The ACES data for this claim is totally unreliable. The ACES spenddown summary reflects a total spenddown liability for the period February 2005 through July 2005 of $3,316.20. (Ex. A-18 at 1101.) But the ACES CME detail sheet reflects that $3,894.00 in expenses was

assigned to spenddown (Ex. D-22 at 4–5). These are conflicting total spenddown amount calculations and fundamentally affect the amount of spenddown assignable to providers.

Further, the ACES CME detail reflects that an Auburn expense for $1,055.00, dated August 11, 2004, was assigned to spenddown. (Ex. D-22 at 5.) This visit was already used to meet spenddown for the period August 2004 through January 2005. (Ex. D-21 at 4.) Pursuant to applicable WAC, this visit cannot be used again to meet spenddown after it has been used to meet spenddown in a prior period. WAC 388-519-0110(1)(a). Worse, while this visit was coded as "unpaid" on the ACES CME for this coverage period, when it was entered for the coverage period August 2004 through January 2005, it was coded "paid." (Ex. D-21 at 4.) Data input for this claim is therefore verifiably inaccurate and cannot be relied upon to make audit findings. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

It also appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with an expense incurred on February 7, 2005. (Ex. D-22 at 74.) According to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) But the medical ID issued on February 24, 2005 (Ex. D-22 at 1) and a letter dated February 24, 2005, informing the patient she had qualified for medically needy benefits, state that her coverage period began on February 1, 2005, a week before she had met his spenddown obligation. (Ex. D-22 at 6.)

Given all the problems with the ACES data relating to this claim, the Hospital respectfully requests that this Court reject the Department's attempt to recover $652.97 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(11) Consuelo F.

19. Claim 19, for Consuelo F., is documented in Ex. D-23 and A-18 pp. 1106–08. Ms. Spencer concluded that the Hospital had been overpaid $1,907.40. (Tr. I:79:24-80:17.) This overpayment claim is not supported by the preponderance of the evidence.

The ACES CME detail sheet states that an Auburn expense of $8,812.40 incurred on October 22, 2002 was used to meet this patient's spenddown obligation. (Ex. D-23 at 8.) However, none of the other evidence on the record reflects that there was ever an expense amount of $8,812.40 from Auburn. Instead, there was an October 20, 2002 expense for $914.75 and an October 22, 2002 expense for $7,897.65. (A-20 at lines B-180, 181.) Ms. Spencer testified that she noticed the discrepancy and simply added the two lines on the HWT report together to get a total expense amount of $8,812.40. (Tr. II:154:14–18.) It is not clear why the caseworker might have entered the data in this way. Irrespective of the reason, this inaccuracy demonstrates the fundamental unreliability of the ACES data input system. Further, Ms. Spencer's arbitrary decision to just add two expenses together to get the "right" amount demonstrates the lack of a reliable, systematic audit methodology.

It also appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with an expense incurred on October 22, 2002. (Ex. D-23 at 8.) According to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) But the medical ID issued on January 27, 2003 (Ex. D-22 at 1) and a letter dated January 27, 2003, informing the patient she had qualified for medically needy benefits, state that her coverage period began on October 1, 2002, about three weeks before she had met her spenddown obligation. (Ex. D-23 at 10.)

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $1,907.40 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(12) Lena F.

21. Claim 21, for Lena F., is documented in Ex. D-25 and A-18 1128–30. Ms. Spencer concluded that the Hospital had been overpaid $466.45. (Tr. I:81:20-25 and 83:10-17.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $1,337.05, but since the Hospital had only been paid $466.45 for the service against which spenddown had been assessed, the Department seeks to recoup $466.45, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $1,337.05. This overpayment claim is not supported by the preponderance of the evidence.

The ACES data for this claim is unreliable. The ACES CME detail sheet lists two expenses attributed to Auburn, one incurred February 6, 2002 for $1,337.05 and another on April 4, 2002 for $4,487.85. (Ex. D-25 at 7–8.) However, the HWT data reflects no expenses for either of these dates. (Ex A-20 at line B-200.) Instead, HWT reflects one expense dated February 26, 2002. (*Id.*) Ms. Spencer testified that she "determined that it was a typing error" and assigned the spenddown to the February 26, 2002 claim paid by the Department. (Tr. I:83:7–8.) Ms. Spencer did not give any reason why it was reasonable to make this assumption, especially in light of the fact that she was similarly unable to find any corroboration for the second apparent Auburn visit, dated April 4, 2002. Like the apparent February 6, 2002 date of service, the hospital had no billing records for this patient corresponding to the April 4, 2002 date. Despite Ms. Spencer's testimony that in her triangulation process, the "date of service is very vital" (Tr. I:65:25), she was evidently satisfied even when the dates of service in ACES and HWT did not match, and even when the hospital has no billing records for the incident of service listed in ACES and to which spenddown has been assigned.

Given the affirmative evidence of the unreliability of the ACES data, it would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

It also appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with the phantom Auburn visit incurred on April 4, 2002. (Ex. D-25 at 7.) According to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) But the medical ID issued on April 26, 2002 (Ex. D-25 at 1) and a letter dated April 26, 2002, informing the patient she had qualified for medically needy benefits, states that her coverage period began on December 1, 2001, about four months before she had "met" her spenddown obligation. (Ex. D-25 at 9.) In fact, however, this patient may never have actually qualified for coverage if it turns out that there was no April 4, 2002 visit.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. The award letter does not specify either a spenddown amount or what bills would be used to meet spenddown. If there is such evidence, it is simply not in the record in this proceeding.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $466.45 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(13) Robert F.

23. Claim 23, for Robert F., is documented in Ex. D-27 and A-18 pp. 1133–34. Ms. Spencer concluded that the Hospital had been overpaid $2,430.00. (Tr. I:84:9-85:7.) This overpayment claim is not supported by the preponderance of the evidence.

The ACES CME detail sheet for this patient reflects that spenddown was assigned to an Auburn expense of $21,432.21 incurred on February 10, 1999. (Ex. D-27 at 5.) But the HWT and hospital billing record data do not have information about a $21,432.21 expense. (Ex. A-20 at line B-202; Ex. D-27 at 2–4.) Unlike for some other claims, Ms. Spencer had no explanation

to offer regarding the difference here. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

It also appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on February 10, 1999. (Ex. D-27 at 5.) According to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) But the medical ID issued on April 6, 1999 (Ex. D-27 at 1) states that his coverage period began on February 1, 1999, ten days before he had met his spenddown obligation.

(14) Carol F.

24. Claim 24, for Carol F., is documented in Ex. D-28 and A-18 pp. 1135–45. Ms. Spencer concluded that the Hospital had been overpaid $902.99. (Tr. I:85:8-86:2.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $2,644.00, but since the Hospital had only been paid $902.99 for the service against which spenddown had been assessed, the Department seeks to recoup $902.99, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $2,664.25.

The ACES data for this claim has some troubling inconsistencies. The ACES spenddown summary states that total spenddown for the period is $3,896.00. (Ex. A-18 at 1135.) But the amount of expenses assigned to spenddown add up only to $3,056.00. (Ex. D-28 at 7, adding up $412 and $2644.) Furthermore, the apparent Auburn expense dated October 28, 2003, for $412.00, turned out not to be an Auburn visit at all even though it was input as an Auburn visit by the caseworker. (Ex. A-18 at 1137; Tr. II:171:8–14.) It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's

calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital. It is not even certain what the total amount of spenddown is supposed to be, and there is no evidence on the record about how that calculation was done and whether the calculation was reliable. Based on the errors discussed above, there is no preponderance of the evidence to support a finding that any number is the correct number.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $902.99 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(15) Carol F.

25. Claim 25, also for Carol F., is documented in Ex. D-29 and A-18 pp. 1135–45. Ms. Spencer concluded that the Hospital had been overpaid $3,660.00. (Tr. I:86:3-87:2.) Recovery of this amount would result in a net payment to the Hospital of $180.86 for a service originally billed at $8,010.75. This overpayment claim is not supported by the preponderance of the evidence.

The ACES CME detail for this coverage period reflects an Auburn expense of $8,344.75 incurred on May 22, 2005. (Ex. D-29 at 8.) But neither HWT nor the Hospital's billing records reflect an expense of that amount for that date. (Ex. A-20 at line B-214; Ex. D-29 at 2–7.) Unlike for some other claims, Ms. Spencer had no explanation to offer regarding the difference here. Further, the Auburn visit is coded as an MC-type expense. According to Ms. Fisher's testimony, this visit should have been coded as an HO-type expense. (*See* Tr. III:114:16–18.) Coding the expense type impacts the computer's determination of what bill is used to meet spenddown. It would be unreasonable to conclude that despite these inconsistencies in the foundational data for Ms. Spencer's calculation, the preponderance of the evidence supports a

conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient for this incident of service. The approval letter does not specify either a spenddown amount or what bills would be used to meet spenddown. (Ex. D-29 at 10–11.) The Hospital's account notes reflect that on May 23, 2005, the Hospital became aware that the patient had a spenddown of $3,660. (Ex. D-29 at 3.) But that same note also states, "Will submit final bill to DSHS for processing and will find out if PT has any other outstanding bills to apply to her spenddown." (*Id.*)

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $3,660.00 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(16) Brian F.

26. Claim 26, for patient Brian F., is documented in Ex. D-30 and A-18 pp. 1146–50. Ms. Spencer concluded that the Hospital had been overpaid $1,188.00. (Tr. I:89:22-90-18.) Recovery of this amount would result in a net payment to the Hospital of $1,054.60 for a service originally billed at $6,297.55. This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary page states that total spenddown for the coverage period at issue is $1,199.00. (Ex. A-18 at 1146.) However, the ACES CME detail page reflects that the caseworker assigned $1,188.00 in spenddown to the apparent Auburn visit. (Ex. D-30 at 8.) There are no other expenses listed in ACES which could possibly be used to meet spenddown. Therefore, the caseworker committed a fundamental error, perhaps in calculating the amount of total spenddown or entering the amount of total spenddown, or perhaps even in entering the amount assigned to the Hospital. Further, the caseworker coded the visit as an MC-type expense,

when it should have been coded as an HO-type expense. (*See* Tr. III:114:16–18.) It would be unreasonable to conclude that despite these errors in the foundational data for Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $1,188.00 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(17) Shannon H.

29. Claims 29 through 33, for Shannon H., are documented in Exs. D-33 through 37 and A-18 pp. 1200–02. On Claim 29, Ms. Spencer concluded that the Hospital had been overpaid $61.60. (Tr. I:105:24-106:16.) Ms. Spencer concluded that the spenddown attributable to the Hospital for Claim 29 was $384.00, but since the Hospital had only been paid $61.60 for the service against which spenddown had been assessed, the Department seeks to recoup $61.60, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $384.00.

On Claim 30, Ms. Spencer concluded that the Hospital had been overpaid $61.60. (Tr. I:106:21-107:13.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $384.00, but since the Hospital had only been paid $61.60 for the service against which spenddown had been assessed, the Department seeks to recoup $61.60, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $384.00.

On Claim 31, Ms. Spencer concluded that the Hospital had been overpaid $73.16. Ms. Spencer concluded that the spenddown attributable to the Hospital was $764.50, but since the Hospital had only been paid $73.16 for the service against which spenddown had been

assessed, the Department seeks to recoup $73.16, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $764.50.

On Claim 32, Ms. Spencer concluded that the Hospital had been overpaid $73.16. Ms. Spencer concluded that the spenddown attributable to the Hospital was $511.50, but since the Hospital had only been paid $73.16 for the service against which spenddown had been assessed, the Department seeks to recoup $73.16, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $511.50.

On Claim 33, Ms. Spencer concluded that the Hospital had been overpaid $1,520.00. Recovery of this amount would result in a net payment to the Hospital of $36.07 for a service originally billed at $3,587.25.

This overpayment claim is not supported by the preponderance of the evidence.

The ACES CME detail page reflects six apparent Auburn expenses (in order as shown on the ACES CME detail page):

7/1/04	384.00
7/7/04	384.00
7/15/04	764.50
7/17/04	511.50
7/8/04	384.00
7/18/04	3,587.25

(Ex. D-33 at 5–6.) However, the expense listed as having been incurred on July 8, 2004, is not reflected in either HWT or the hospital's account records. (*See* A-20 at lines B-257–262, Exs. D-33, 34, 35, 36, 37.) A note on one copy of the ACES CME detail page states "No bill for DOS or $, per HWT." (Ex. A-18 at 1202.) Ms. Spencer testified that she was unable to obtain a copy of this bill from the Hospital. (Tr. I:115:9–11.) Thus the evidence suggests that at least one piece of data in the ACES system for this claim is entirely illusory. There is no reason, in light of this deficiency, to place any reliance on the other uncorroborated data in the ACES system for this claim, including the total spenddown liability calculated for this patient. It would

be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital. It appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with an expense incurred on July 18, 2004. (Ex. D-33 at 6.) According to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) But the medical ID issued on October 28, 2004 (Ex. D-33 at 1) and a letter dated August 27, 2004, informing the patient she had qualified for medically needy benefits, state that her coverage period began on July 1, 2004, almost three weeks before she had met her spenddown obligation. (Ex. D-33 at 7.) Further, the approval letter does not specify either a spenddown amount or what bills would be used to meet spenddown.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $61.60 on Claim 29, $61.60 on Claim 30, $73.16 on Claim 31, $73.16 on Claim 32, and $1,520.00 on Claim 33. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(18) Stephanie H.

36. Claims 36 and 37, for Stephanie H., are documented in Exs. D-39, D-40 and A-18 pp. 1249–54. Ms. Spencer concluded that the Hospital had been overpaid $41.57 on Claim 36 and $3,238.36 on Claim 37. (Tr. I:136:21-137:1.) On Claim 36, Ms. Spencer concluded that the spenddown attributable to the Hospital was $191.44, but since the Hospital had only been paid $41.57 for the service against which spenddown had been assessed, the Department seeks to recoup $41.57, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $301.25. On Claim 37, Ms. Spencer concluded

that the spenddown attributable to the Hospital was $3,508, but since the Hospital had only been paid $3,238.36 for the service against which spenddown had been assessed, the Department seeks to recoup $3,238.36, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $7,480.20. These overpayment claims are not supported by the preponderance of the evidence.

The ACES CME detail page lists fourteen expenses, six of which are attributed to the Hospital.

11/27/04	965.25	MC	used
11/28/04	201.25	MC	split
11/28/04	**301.25**	**MC**	**not used**
01/13/05	**1,209.50**	**MC**	**not used**
01/13/05	801.25	MC	not used
02/07/05	3,508.00	HO	used

(Ex. D-39 at 16–19.) Of these six expenses, only the two in bold text correspond to HWT line items in the MN universe of claims Ms Spencer had available to her at the time she performed her audit. (Ex. A-20 lines B-285, 286.) The HWT database had one line item which was for a date of service within the coverage period at issue, but which did not appear in ACES. (Ex. A-20 line B-287.)

The Department subsequently produced another, more-recently run query of the HWT database. (Ex. D-39 at 2.) But like the results from the older query, the data from the newer HWT query and the ACES data did not match up well. When asked about a line item on the newer query, the $1,999.65, Ms. Spencer could not at first explain what that line item was or why it hadn't appeared in the hospital records produced by the Department. (Tr. I:143–147.) Later, after a break, Ms. Spencer was able to explain that the $1,999.65 was a bill relating to the patient's baby. (Tr. I:155:1–10.)

Further, Claim 37 attempts to assess an overpayment on a service reflected in HWT as having been incurred on February 7, 2005 and billed at $7,480.20. (Dept's FINAL-Amended

Audit at Line C3-37.) But the spenddown Ms. Spencer attributed to this HWT line item was, in ACES, assigned to an apparent Auburn expense of $3,508.00. This information simply does not match. Unlike for some other claims, Ms. Spencer had no explanation to offer regarding the difference here.

All of this goes to show that the ACES data relating to this claim for overpayment is fundamentally flawed. It does not match actual billing, as reflected in either HWT or in hospital records. Even more troubling, the HWT information is itself unstable. The report run at the time Ms. Spencer did her audit contains information different from a report run later. Yet ACES and HWT are Ms. Spencer's primary sources of information upon which she relies to make her findings. The Accounting Standards clearly state that "evidence has limitations or uncertainties when the validity of reliability of the evidence has not been assessed or cannot be assessed. Limitations also include errors identified by the auditors in their testing. When the auditors identify limitations or uncertainties in evidence that is significant to their findings and conclusions, they should apply additional procedures as appropriate. Such procedures include . . . seeking independent, corroboration evidence from other sources." AUDITING STANDARDS 153.

It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $41.57 on Claim 36 and $3,238.36 on Claim 37. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(19) Lowell H.

38. Claim 38, for Lowell H., is documented in Ex. D-41 and A-18 pp 1265–71. Ms. Spencer concluded that the Hospital had been overpaid $848.13. (Tr. I:157:20-158:13.) This overpayment claim is not supported by the preponderance of the evidence.

The ACES CME detail page reflects an Auburn expense of $900.00 incurred on August 23, 1999. (Ex. D-41 at 5.) The HWT data for this date of service, however, reflects an expense amount of $55,760.15. (Ex. A-20 at line B-307.) Unlike for some other claims, Ms. Spencer had no explanation, other than mere speculation, to offer regarding the difference here. (Tr. I:158:17–20, stating "I don't have any definite reason why that amount.") Despite this unexplained inconsistency between the ACES and the HWT data, Ms. Spencer concluded that the spenddown assigned by the caseworker to a $900 expense was properly assignable to the HWT expense of $55,760.15.

It also appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on August 23, 1999, for the coverage period August 1–31, 1999. (Ex. D-41 at 5.) According to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) But the medical ID issued on December 1, 1999 (Ex. D-41 at 1) states that his coverage is from August 1, 1999 through December 31, 1999, putting his coverage begin date three weeks before he met his spenddown requirement. Meanwhile, a letter dated December 1, 1999, informed the patient he had qualified for medically needy benefits and stated that his coverage period went from September 1, 1999 through February 29, 2000. (Ex. D-41 at 6.) None of these sources of information square with one another, and call into serious question the integrity of the other data used by Ms. Spencer to calculate the alleged overpayment.

It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage

period at issue, and then to assess an overpayment against the Hospital. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $848.13 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(20) Paulette H.

39. Claims 39 and 40, for Paulette H., are documented in Ex. D-42, D-43 and A-18 pp. 1274–80. Ms. Spencer concluded that the Hospital had been overpaid $675.00 on Claim 39 and $180 on Claim 40. (Tr. I:159:23-16.)

This patient met her spenddown for coverage period October 1, 2003 through March 31, 2004 with an Auburn expense incurred on October 2, 2003. (Ex. D-42 at 6.) But the medical ID she was issued on December 2, 2003, reflected a coverage period beginning October 1, 2003 and ending on December 31, 2003. (Ex. D-42 at 1.) Meanwhile, her approval letter, also dated December 2, 2003, informed her that she had coverage from October 1, 2003 through March 31, 2004. (Ex. D-42 at 7.) This approval letter did not specify either a spenddown amount or what bills would be used to meet spenddown.

Despite the fact that this patient had valid coverage through March 31, 2004, an ACES CME detail page for the next coverage period reflects that an expense attributed to Auburn and incurred on March 2, 2004, was assigned spenddown. But this visit should have been covered and paid under this patient's coverage valid through March 31, 2004. And as an expense already covered and paid by Medicaid, it should not have been used to meet spenddown for a subsequent period. Because spenddown was improperly assessed on this expense, the Hospital respectfully requests that this Court reject the Department's attempt to recover $180.00 on Claim 40. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(21) James M.

49. Claim 49, for James M., is documented in Ex. D-52, and A-18 pp. 1410–14. Ms. Spencer concluded that the Hospital had been overpaid $344.71 on Claim 49. (Tr. I:180:12-23.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $948, but since the Hospital had only been paid $344.71 for the service against which spenddown had been assessed, the Department seeks to recoup $344.71, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $1,217.00. This overpayment claim is not supported by a preponderance of the evidence.

The ACES CME detail page reflects that $948 of spenddown is assigned to an Auburn visit. (Ex. D-52 at 5.) But the ACES spenddown summary page reflects that $880 is the total spenddown liability for the relevant period. The approval letter also cites a total spenddown amount of $880. (Ex. D-52 at 6.) Ms. Spencer was stymied by this discrepancy. (Tr. I:188:5–12.) Furthermore, the Auburn visit is coded as an MC-type expense, when it should be coded as an HO-type expense. (*See* Tr. III:114:16–18.) It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $344.71 on Claim 49. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(22) Daniel M.

50. Claim 50, for Daniel M., is documented in Ex. D-53 and A-18 pp. 1420–21. Ms. Spencer concluded that the Hospital had been overpaid $3,612.00. (Tr. I:189:4-22.) This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary page states that the total spenddown liability for the coverage period at issue is $3,637.00. (Ex. A-18 at 1420.) But the ACES CME detail page shows that only $3,612.00 of the sole visit listed has been used to meet spenddown. (Ex. D-53 at 8.) Ms. Spencer was stymied by this discrepancy. (Tr. I:192.) This discrepancy casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period.

The approval letter for this patient is of no help. (Ex. D-53 at 9–10.) It does not specify either a spenddown amount or what bills would be used to meet spenddown. Without more information, there is no way to validate any total spenddown liability figure. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $3,612 on Claim 50. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(23) Michael M.

51. Claim 51, for Michael M., is documented in Ex. D-54 and A-18 pp. 1445–48. Ms. Spencer concluded that the Hospital had been overpaid $2,359.06. (Tr. I:193:189-190:12.) Recovery of this amount would result in a net payment to the Hospital of $286.45 for a service originally billed at $6,558.05. This overpayment claim is not supported by the preponderance of the evidence.

The ACES CME detail page states that the visit being used to meet spenddown is an expense incurred by Juanita M. (Ex. D-54 at 5.) But neither HWT nor the hospital records have any record of a visit for Juanita M. (Ex. A-20 at line 467; D-54 at 2–4.) Furthermore, while spenddown appears to have been met on November 3, 1999 (Ex. D-54 at 5), the medical ID

issued on March 1, 2000 states that coverage starts on November 1, 1999 (Ex. D-54 at 1). The approval letter also states that coverage begins on November 1, 1999. (Ex. D-54 at 6.) These discrepancies highlight the unreliability of the ACES data. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $2,359.06 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(24) Sandra M.

53. Claim 53, for patient Sandra M., is documented in Ex. D-56 and A-18 pp. 1456–61. Ms. Spencer concluded that the Hospital had been overpaid $70.92. (Tr. II:182:16-183:14.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $88.00, but since the Hospital had only been paid $70.92 for the service against which spenddown had been assessed, the Department seeks to recoup $70.92, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $105.00. This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary page states that the total spenddown liability for this period is $235.00. (Ex. A-18 at 1459.) The ACES CME detail page reflects, however, that $270 of spenddown was assigned to the two expenses listed. Ms. Spencer did not have any explanation for this discrepancy. This discrepancy casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period.

The approval letter for this patient is of no help. (Ex. D-55 at 6–7.) It does not specify either a spenddown amount or what bills would be used to meet spenddown. It does not contain any information about how spenddown was calculated. Without more information, there is no

way to validate any total spenddown liability figure. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital. The Court should note, too that the Auburn visit is miscoded as an MC-type expense when it should have been coded as HO-type. (*See* Tr. III:114:16–18.) For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $70.92 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(25) Marlene N.

57. Claims 57 and 58, for Marlene N., are documented in Ex. D-60, D-61 and A-18 pp. 1485–91. Ms. Spencer concluded that the Hospital had been overpaid $3,029.54 on Claim 57 and $69.84 on Claim 58. (Ex. D-5 at line C3-57, 58.) On Claim 57, recovery of the alleged overpayment amount would result in a net payment to the Hospital of $1,501.92 for a service originally billed at $6,370.35. On Claim 58, recovery of the alleged overpayment amount would result in a net payment to the Hospital of $0 for a service originally billed at $482.00. These overpayment claims are not supported by the preponderance of the evidence.

The ACES CME detail page relevant to Claim 57 reflects an expense amount attributed to Auburn of $4,631.59 incurred on January 27, 2003. (Ex. D-60 at 7.) But neither HWT nor hospital records match this information. HWT reflects an expense amount of $6,370.35 (Ex. A-20 at line B-491), while the hospital records reflect both a pre-adjustment amount of $6,370.35 and an adjusted amount of $4,531.59 (Ex. D-60 at 4.) During the hearing, Ms. Spencer speculated, without foundation, that the discrepancy was due to an input error. (Tr. III:15:12.)

It further appears that the Department may have miscalculated this patient's eligibility period relating to Claim 57. According to ACES, this patient met her spenddown with an expense incurred on January 27, 2003. (Ex. D-60 at 7.) According to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) But the medical ID issued on June 24, 2003 (Ex. D-60 at 1), and a letter dated the same day, state that her coverage period began on January 1, 2003, almost a month before she had met her spenddown obligation. (Ex. D-60 at 8.) Further, the approval letter does not specify either a spenddown amount or what bills would be used to meet spenddown.

The aggregate nature of these errors casts doubt onto the reliability and integrity of the ACES information on which Ms. Spencer relied to make her audit findings. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 57. For this reason, the Hospital respectfully requests that this Court reject the Department's attempt to recover $3,029.54 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

With respect to Claim 58, the ACES spenddown summary states that total spenddown liability for the relevant coverage period is $2,932.00. (Ex. A-18 at 1487.) But the total spenddown assigned, as reflected on the ACES CME detail page, is only $2,910. (Ex. D-61 at 10–11; adding $449.50 + $2,160.50 + $300.) This discrepancy casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period.

The approval letter for this patient is of no help. (Ex. D-61 at 12–13.) It does not specify either a spenddown amount or what bills would be used to meet spenddown. Without more information, there is no way to validate any total spenddown liability figure. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of

data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

In addition to these discrepancies with respect to total spenddown liability for the period, the ACES CME detail page lists two visits which are nowhere reflected in the HWT data available to Ms. Spencer at the time she performed her audit. (Compare Ex. D-61 at 10-11, listing an Auburn expense of $2,160.50 incurred 7/15/03 and an Auburn expense of $300 incurred 7/8/03; and A-20, no corresponding line items.) Given that when Ms. Spencer performed her audit she had no HWT corroboration for two of the three expenses listed in ACES, it was arbitrary of her to continue to rely on the ACES data to make her audit findings.

Finally, the ACES CME detail page reflects that all three visits, attributed to Auburn, are coded as MC-type expenses when they should have been coded as HO-type expenses. (*See* Tr. III:114:16–18.)

The aggregate nature of these errors casts doubt onto the reliability and integrity of the ACES information on which Ms. Spencer relied to make her audit findings. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 58. For this reason, the Hospital respectfully requests that this Court reject the Department's attempt to recover $69.84 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(26) Patricia N.

61. Claim 61, for Patricia N., is documented in Ex. D-64 and A-18 at pp. 1512–14. Ms. Spencer concluded that the Hospital had been overpaid $5,842.00. (Tr. III:32:15-33:13.) Recovery of this amount would result in a net payment to the Hospital of $1,303.56 for a service

originally billed at $12,050.45. This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary page states that total spenddown liability for the period at issue is $8,190.00. (Ex. A-18 at 1512.) However, the ACES CME detail page reflects that only $5,842 in spenddown was assigned to the two expenses listed, even though expenses together total more than $8,190. (Ex. D-64 at 8.) This discrepancy casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. When Ms. Spencer was asked to explain why a much smaller amount of spenddown than the total was assigned to the two expenses on the ACES CME detail, she speculated, with absolutely no foundation, that there might have been other bills to which spenddown has been assigned that had not been entered into ACES. (Tr. III:37.)

The approval letter for this patient is of no help. (Ex. D-64 at 10–11.) It does not specify either a spenddown amount or what bills would be used to meet spenddown. Without more information, there is no way to validate any total spenddown liability figure.

In addition to the discrepancy in the total spenddown liability, there is also a discrepancy with respect to the expenses. The ACES CME detail page lists an Auburn expense of $8,642.65 incurred on February 18, 2002. (Ex. D-64 at 8.) But the HWT data does not contain any data relating to an expense of $8,642.65 for this patient. (Ex. A-20 lines B-527, 528.) The Hospital account records do not correspond to this expense amount either. (Ex. D-64 at 2–7.) Ms. Spencer had no explanation for this discrepancy. (Tr. III:35.)

The aggregate nature of these errors casts doubt onto the reliability and integrity of the ACES information on which Ms. Spencer relied to make her audit findings. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 61. For this reason, the Hospital respectfully requests that this Court reject the Department's attempt to recover $5,842 on this

claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(27) David P.

63. Claim 63, for David P., is documented in Ex. D-66 and A-18 pp. 1536–38. Ms. Spencer concluded that the Hospital had been overpaid $1,367.20. (Tr. III:45:22-46-17.) This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary page states that total spenddown liability for the period June 1999 through November 1999 would be $867.20. (Ex. A-18 at 1536.) But the ACES CME detail page reflects that $1,367.20 of spenddown was assigned to an Auburn expense incurred August 27, 1999. (Ex. D-66 at 5.) The approval letter does little to enlighten. First, it states that coverage begins June 1, 1999 (Ex. D-66 at 6), when according to the ACES CME detail page, coverage could not begin until August 27, 1999 (Ex. D at 5). It also appears to say that spenddown assigned to the Auburn visit is $0. (Ex. D-66 at 6.) The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Spencer relied to make her audit findings. The discrepancies particularly cast into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. At the hearing, Ms. Spencer acknowledged the discrepancies but offered no explanation or rationale for why or how she had resolved the discrepancy in the Department's favor. In light of the fundamental flaws in the data, it was arbitrary for Ms. Spencer to have relied on the ACES data in the way she did.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Spencer's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 63. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $1,367.20 on this

claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(28) Jack P.

64. Claim 64, for Jack P., is documented in Ex. D-67 and A-18 at pp. 1544–47. Ms. Spencer concluded that the Hospital had been overpaid $513.94. (Tr. III:49:20-50:7; 50:19-51:4.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $1,557.75, but since the Hospital had only been paid $513.94 for the service against which spenddown had been assessed, the Department seeks to recoup $513.94, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $1,557.75. This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary page states that total spenddown liability for the period July 2001 through December 2001 was $2,211.50. (Ex. A-18 at 1544.) But the ACES CME detail page for that same page reflects that the caseworker assigned $2,951.50 in spenddown to the expenses entered in the ACES system. (Ex. D-67 at 5–6; Tr. III:53:3–1.) This discrepancy casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period.

A potential source of corroboration for Ms. Spencer's findings, the award letter, is also unreliable as a source of information. The ACES CME detail page reflects that this patient did not meet his spenddown obligation until August 29, 2001. (Ex. D-67 at 5.) But the award letter states that the patient is eligible to receive coverage benefits starting July 1, 2001. According to the applicable WAC, 388-519-0110(7), and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) The award letter is wrong and cannot be relied on as a source of data.

At the hearing, Ms. Spencer acknowledged the discrepancies but offered no explanation or rationale for why or how she had resolved the discrepancy in the Department's favor. In light

of the fundamental flaws in the data, it was arbitrary for Ms. Spencer to have relied on the ACES data in the way she did.

It would be unreasonable for this Court to now conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 64. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $513.94 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(29) Lonnie P.

66. Claim 66, for Lonnie P., is documented in Ex. D-69 and A-18 pp. 1553–58. Claim 67, for Vernice P., is documented in Ex. D-70 and A-18 pp. 1553–58. Lonnie P. and Vernice P. are in the same assistance unit, so their bills can be used to meet each other's spenddown obligation. (Ex. A-18 at 1556.) Ms. Spencer concluded that the Hospital had been overpaid $319.57 on Claim 66 and $80.00 on Claim 67. (Tr. III:56:16-22; 57:7-16.)

On Claim 66, Ms. Spencer concluded that the spenddown attributable to the Hospital was $900.00, but since the Hospital had only been paid $319.57 for the service against which spenddown had been assessed, the Department seeks to recoup $319.57, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $900.00. On Claim 67, Ms. Spencer concluded that the spenddown attributable to the Hospital was $1,380.00, but the Department seeks to recoup $80 because the Department had already deducted $1,300 from its payment to the Hospital. Claims 66 and 67 are not supported by a preponderance of the evidence.

The ACES CME detail for Lonnie P. reflects that the applicable spenddown period is August 2002 through January 2003. (Ex. D-69 at 7.) The ACES CME detail for Vernice P.

reflects that she was assigned a spenddown period of October 2002 through March 2003. (Ex. D-70 at 9.) At the hearing, Ms. Spencer could not explain why two members of the same assistance unit would have been assigned overlapping coverage periods or what effect such an overlap would have on each patient's spenddown obligations. (Tr. III:67.) The Department has presented no evidence from which it would be possible to determine whether the total spenddown liability for either Lonnie P. or Vernice P. was properly calculated. While their record does contain an award letter for Lonnie P., that letter contains no specific information about total spenddown liability, what bills were used to meet spenddown, or how spenddown was calculated. (Ex. D-69 at 9.) As for Vernice P., there is no award letter for her at all. So there is no way for the Department to demonstrate that it calculated the spenddown liability for either of these two patients correctly. Without a reliable calculation of total spenddown liability, Ms. Spencer's audit analysis cannot be performed on these two patients. It would be arbitrary to try to calculate an assessment, and it would be arbitrary to accept the analysis that was already done. The analysis was not supported by a preponderance of the evidence.

Furthermore, the ACES CME detail page for Vernice lists an expense of $8,322.30 attributed to Auburn, and incurred on December 31, 2002. (Ex. D-70 at 9.) But the HWT data contains no expense for $8,322.30. (A-20 at lines B-555, 556, 557.) And unlike for some other claims, Ms. Spencer had no explanation to offer regarding the difference here.

The aggregate effect of these deficiencies casts doubt onto the reliability and integrity of the ACES information on which Ms. Spencer relied to make her audit findings. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claims 66 and 67. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $319.57 on Claim 66 and $80.00 on Claim 67. Furthermore, the Hospital requests that the Department repay the Hospital the $1,300 already deducted from the payment to the Hospital on Claim 67,

because the spenddown calculation underlying that amount is tainted by the same deficiencies discussed above. In so requesting, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(30) Patricia Q.

68. Claims 68 and 69, for Patricia Q., are documented in Ex. D-71 and A-18 pp. 1559–65. Ms. Spencer concluded that the Hospital had been overpaid $2,548.00 on Claim 68 and $3,879.00 on Claim 69. (Tr. III:68:13-69:8.) Recovery of these amounts would result in a net payment to the Hospital of $2,690.03 on Claim 68, for a service originally billed at $11,629.00, and $3,806.99 on Claim 69, for a service originally billed at $16,820.90. These claims are not supported by a preponderance of the evidence.

With respect to Claim 68, the ACES CME detail page reflects an expense of $2,548, incurred on April 26, 2001, and attributed to the Hospital. (Ex. D-71 at 8.) But the HWT line item for this date of service has a different amount, $11,629.00. (Ex. A-20 at line B-558.) The hospital records (Ex. D-71 at 2–7) also do not match up with the expense data reflected on the ACES CME detail page. Ms. Spencer acknowledged the discrepancy in these amounts. (Tr. III:72.) Unlike for some other claims, Ms. Spencer had no explanation to offer regarding the difference here.

In addition to this failure to square with other data sources, the visit at issue was coded as an MC-type expense when it should have been coded as an HO-type expense, if the expense had truly been from the Hospital. (*See* Tr. III:114:16–18.)

With respect to Claim 69, the ACES CME detail page reflects an expense of $5,424.00, incurred on October 4, 2001, and attributed to the Hospital. (Ex. D-72 at 5.) But the HWT line item for this date of service has a different amount, $16,820.90. (Ex. A-20 at line B-566.) The hospital records (Ex. D-72 at 2–4) also do not match up with the expense data reflected on the ACES CME detail page. Unlike for some other claims, Ms. Spencer had no explanation to offer regarding the difference here.

Furthermore, the ACES spenddown summary page states that total spenddown for the period was $3,816.00. (A-18 at 1563.) But the ACES CME detail page for the same coverage period shows that the caseworker assigned $3,879.00 of spenddown to the visit that had been attributed to the Hospital. This discrepancy casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period.

The approval letter for this patient is of no help. (Ex. D-72 at 6.) It does not specify either a spenddown amount or what bills would be used to meet spenddown. Without more information, there is no way to validate any total spenddown liability figure.

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Spencer relied to make her audit findings. Not only is the total spenddown amount unreliable, the ACES spenddown assignment data is also unreliable. At the hearing, Ms. Spencer offered no explanation or rationale for why or how she had resolved the discrepancy in the Department's favor. In light of the fundamental flaws in the data, it was arbitrary for Ms. Spencer to have relied on the ACES data in the way she did. It would be unreasonable for the Court to now permit the Department, on the basis of the arbitrary findings, to recoup any monies from the Hospital.

For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $2,548.00 on Claim 68 and $3,879 on Claim 69. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(31) Dixie R.

72. Claim 72, for Dixie R., is documented in Ex. D-75 and A-18 pp. 1604–05. Ms. Spencer concluded that the Hospital had been overpaid $2,206.50. (Tr. III:86:14-87:6.) This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary page for the applicable coverage period states that total spenddown liability is $2,216.50. (Ex. A-18 at 1604.) However, the ACES CME detail page

reflects that $2,206.50 total in spenddown was assigned to the single visit entered into the system. (Ex. D-75 at 4.) This discrepancy casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. In this particular case, Ms. Spencer decided to assess the lower amount against the Hospital. But in other claims with similar discrepancies, she has not opted to resolve the discrepancy in the Hospital's favor. In any event, the Hospital disputes that even the lower amount can be assessed as an overpayment because of other inaccuracies in the data.

The ACES CME detail page lists an expense of $5,443.00 for an October 21, 2000 date of service. (Ex. D-75 at 4.) But there is no HWT line item for an expense amount of $5,443.00. Instead, the HWT data reflects a charge of $6,623.50 for an October 21, 2000 date of service. (Ex. A-20 at line B-593.) Hospital records also do not match the ACES data. (Ex. D-75 at 2–3.) Unlike for some other claims, Ms. Spencer had no explanation to offer regarding the difference here. This inaccuracy, together with the problems with the total spenddown amount data, calls into question the reliability and integrity of the ACES information on which Ms. Spencer relied to make her audit findings. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 72.

Furthermore, it appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with an expense incurred on October 21, 2000. (Ex. D-75 at 4.) According to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) But the medical ID issued on October 24, 2000 (Ex. D-75 at 1), and a letter dated the same day, state that her coverage period began on August 1, 2000, almost three months before she had met her spenddown obligation. (Ex. D-75 at 5.)

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover $2,206.50 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(32) Richard S.

74. Claim 74, for Richard S., is documented in Ex. D-77 and A-18 pp. 1640–47. (This is not the Richard S. documented in D-76.) Ms. Spencer concluded that the Hospital had been overpaid $4,750.21. (Tr. III:186:8-187:15.) Ms. Spencer concluded that the spenddown attributable to the Hospital was $8,079.55, but since the Hospital had only been paid $4,750.21 for the service against which spenddown had been assessed, the Department seeks to recoup $4,750.21, the amount paid. Recovery of this amount results in a net payment to the Hospital of $0 for a service originally billed at $7,860.55. This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary page states that this patient has $0 spenddown liability for the coverage period at issue. (Ex. A-18 at 1640). Yet the ACES CME detail page reflects several thousands dollars of spenddown assigned to three different expenses entered into the ACES system. (Ex. D-77 at 6.) Ms. Spencer acknowledged this discrepancy but did not explain how or why she had chosen to resolve the discrepancy in the Department's favor and assess a $4,750.21 overpayment against the Hospital. The approval letter for this patient is of no help. (Ex. D-77 at 7.) It does not specify either a spenddown amount or what bills would be used to meet spenddown. Without more information, there is no way to validate any total spenddown liability figure. This unexplained discrepancy casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period.

In addition, Ms. Spencer testified at the hearing that two of the expenses listed on the ACES CME detail page turned out not to have been Hospital expenses *at all*, even though they were entered into ACES as Auburn visits. (Tr. III:192–93.) Finally, the ACES expense whose

spenddown Ms. Spencer assigned to the Hospital is an expense from May 25, 2004 for $8,079.55. (Ex. D-77 at 6.) But neither HWT nor the hospital records square with this data. HWT lists a charge from May 25, 2004 for $7,860.55. (A-20 at line B-612.) The hospital records also do not match. Unlike for some other claims, Ms. Spencer had no explanation to offer regarding the difference here.

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Spencer relied to make her audit findings. In light of the fundamental flaws in the data, it was arbitrary for Ms. Spencer to have relied on the ACES data in the way she did. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 74. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $4,750.21 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(33) Sandra S.

75. Claim 75, for Sandra S., is documented in Ex. D-78 and A-18 pp. 1656–59. Ms. Spencer concluded that the Hospital had been overpaid $573.00. (Tr. III:196:15-197:10.) This overpayment claim is not supported by the preponderance of the evidence.

The coverage period at issue went from September 2004 through November 2004. (Ex. D-78 at 11.) The total spenddown for this period of time was $573.00. (Ex. D-78 at 11.) The ACES CME detail page lists an expense attributed to the Hospital of $40,058.57, incurred on November 23, 2004. (Ex. D-78 at 12.) According to this record, spenddown was assigned to this expense. (Ex. D-78 at 12.) But the HWT data for this date of service reflects a charge for $34,279.02 — this does not match the ACES data. (Ex. A-20 at line B-635.) Unlike for some

other claims, Ms. Spencer had no explanation to offer regarding the difference here. Furthermore, a letter dated April 14, 2005, but discussing the coverage period from September through November 2004 (Ex. D-78 at 14) assigned the spenddown to an expense for $17,365.08 from St. Joseph Hospital (Ex. D-78 at 13).

The aggregate effect of these discrepancies is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Spencer relied to make her audit findings. At the hearing, Ms. Spencer acknowledged the discrepancies but offered no explanation or rationale for why or how she had resolved the discrepancy in the Department's favor. In light of the fundamental flaws in the data, it was arbitrary for Ms. Spencer to have relied on the ACES data in the way she did.

It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 75. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $573.00 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

(34) Jody W.

77. Claim 77, for Jody W., is documented in Ex. D-80 and A-18 pp. 1729–34. Ms. Spencer concluded that the Hospital had been overpaid $60.46. (Tr. IV:14:23-15:13.) Recovery of this amount would result in a net payment to the Hospital of $0 for a service originally billed at $403.75. This overpayment claim is not supported by the preponderance of the evidence.

The ACES spenddown summary page states that total spenddown liability for the period at issue is $152.00. (Ex. A-18 at 1729.) But the ACES CME detail page reflects that $156.00 of

spenddown was assigned to the Auburn visit entered into ACES. (Ex. D-80 at 4.) This discrepancy casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period.

The approval letter for this patient is of no help. (Ex. D-80 at 9–10.) It is not a reliable source of information. While this patient did not meet her spenddown until June 5, 2001 (and therefore her coverage could not have begun until June 5, 2001), the award letter states that her coverage began on June 1, 2001. But according to applicable WAC, 388-519-0110(7) and the Department's witnesses, coverage begins only once spenddown has been met. (Tr. I:49:24–25 (Ms. Spencer); Tr. III:101:14–18 (Ms. Fisher).) Without a different, reliable source of information, there is no way to validate any total spenddown liability figure.

In light of the fundamental flaws in the data, it was arbitrary for Ms. Spencer to have relied on the ACES data in the way she did. It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Spencer's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 77. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover $60.46 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

APPENDIX B

Explanation of Table

This table collects certain data about each of Department's 72 overpayment claims. The Hospital's position, as further elaborated in the Hospital's Post-Hearing brief, is that all of the overpayment claims should be rejected for systemic and pervasive problems in the methodology and execution of the audit and in the underlying data relied on in the audit. However, should the Court decline to reject the Department's findings wholesale, the following table highlights overpayments with specific problems that support a finding by this Court that the Department has failed to satisfy its burden of proof with respect to those particular claims.

The claims the Hospital believes should be rejected on a claim-by-claim basis are in gray boxes. Each claim is discussed in further detail in the body of the brief.

The source of the data in the table in indicated in parentheses in the column headings. There is only one calculated column, called "Net Payment to Hospital After Recovery."

The data in the table is as follows:

1. **Claim #** — the ordinal number of the Department's claim, corresponding to the Department's "W/P REF" column in its audit spreadsheet

2. **Line #** (HWT) — the B-number on Ex. A-20, the Department's HWT spreadsheet

3. **Patient Name** (HWT) — the patient's first name and last initial, derived from the information in HWT

4. **Service Date** — the beginning and ending dates of service, as reflected in HWT

5. **Date Expense Attributed to Auburn Incurred** (ACES) — the date listed in the ACES CME detail page as entered by a caseworker

6. **RECIP PMT** (HWT)

7. **TOTAL CHARGES** (HWT)

8. **Expense Amount Attributed to Auburn** (ACES)

9. **DSHS Payment** (HWT)

10. **SD/EMER assign** (Spencer) — this comes from the Department's audit spreadsheet

00032

11. **Client Liability Amount** (ACES) — ACES data contains information in this field only when there is a split bill. However, for purposes of this demonstrative table, the Hospital has populated this field with data even when a whole bill is used towards spenddown. If a whole bill is used, the amount of the bill is entered into this field.

12. **Total due DSHS** (Spencer) — this comes from the Department's audit spreadsheet

13. **Spenddown period** (ACES) — the spenddown period as reflected in ACES

    Spenddown for period (ACES) — the total spenddown amount for the period, as reflected on the ACES spenddown summary page

14. **Net Payment to Hospital After Recovery** — calculated by subtracting the "Total due DSHS" from "DSHS Payment"

15. **Expense type** (ACES) — expense type assigned to the expense assigned to the Hospital as reflected on ACES CME detail page

16. **Spenddown use of expense attributed to Auburn** — as reflected on ACES CME detail page

The data in the table has been placed to enable the following key comparisons, among others:

- Service Date, as reflected in HWT, vs. Date Expense Attributed to Auburn Incurred, as reflected in ACES
- Total Charges, as reflected in HWT, vs. the expense amount attributed to Auburn in ACES
- DSHS payment, as reflected in HWT, vs. "SD/EMER assign" (the amount of spenddown Ms. Spencer concluded was assigned to Auburn)
- "SD/EMER assign" vs. Client Liability Amount vs. Total due DSHS vs. Spenddown for period

APPENDIX 1
To Appellant's Post-Hearing Brief

Claim #	Line # (HWT)	Patient Name (HWT)	Service Date (HWT)	*Date Expense Attributed to Auburn Incurred (ACES)*	"RECIP PMT" (HWT)	TOTAL CHARGES (HWT)	*Expense Amount Attributed to Auburn (ACES)*	DSHS Payment (HWT)	"SD/EMER assign" (Spencer)	*Client Liability Amount (ACES)*	Total due DSHS (Spencer)	*Spenddown period (ACES)* *Spenddown for period (ACES)*	Net Payment to Hospital After Recovery	*Expense Type (ACES)*	*Spenddown use of expense attributed to Auburn (ACES)*
= claim not supported by the preponderance of the evidence															
1	B-2	SIONE A.	07/23/04	07/25/04	07/23/04	$0.00	$8,853.35	8,853.35	$5,317.67	4,506.00	4,506.00	4,506.00	*07/04-12/04* *5,556.00*	$811.67	MC	Split
2	B-13	MICHAEL A.	10/15/03	10/20/03	10/15/03	$0.00	$7,000.75	1,700.75	$6,351.87	952.00	952.00	952.00	*10/03-12/03* *952.00*	$5,399.87	HO	Split
3	B-18	ROBERTO A.	12/17/04	12/18/04	12/17/04	$0.00	$10,607.43	10,607.43	$3,007.71	144.48	144.48	144.48	*12/04-05/05* *144.48*	$2,863.23	MC	Split
4	B-19	MARJORIE A.	11/23/02	11/23/02	11/23/02	$0.00	$2,811.10	2,830.00	$815.41	1,634.00	1,634.00	815.41	*08/02-01/03* *2,970.00*	$0.00	MC	Split
6	B-32	PATRICIA B.	10/01/99	10/01/99	10/01/99	$0.00	$1,031.25	1,031.25	$354.11	1,031.25	1,031.25	354.11	*10/99-3/00* *1,370.50*	$0.00	HO	Used
7	B-45	MINNIE B.	01/02/02	01/02/02	01/02/02	$0.00	$305.75	305.75	$61.70	198.17	198.17	61.70	*01/02-06/02* *540.42*	$0.00	HO	Split
8	B-60	STEVEN B.	01/27/99	01/27/99	01/27/99	$0.00	$729.25	729.25	$352.96	591.54	729.25	352.96	*1/99-3/99* *9,880.54*	$0.00	HO	Used
9	B-61	DELORES B.	03/04/00	03/04/00	03/04/00	$0.00	$621.00	621.00	$182.79	274.14	274.14	182.79	*03/00-08/00* *274.14*	$0.00	HO	Split
10	B-90	CHRISTOPHER C.	01/24/00	01/24/00	01/24/00	$0.00	$543.57	352.82	$129.06	120.00	120.00	120.00	*01/00-06/02* *120.00*	$9.06	HO	Split
11	B-111	LARRY C.	04/14/02	04/15/02	04/14/02	$0.00	$5,306.35	5,563.85	$2,055.92	1,305.00	1,305.00	1,305.00	*4/02-9/02* *1,305.00*	$750.92	HO	Split
12	B-119	CONNIE D.	11/15/00	11/17/00	11/15/00	$0.00	$7,441.50	4,883.18	$4,883.18	2,167.04	2,167.04	2,167.04	*11/00-04/01* *2,167.04*	$2,716.14	HO	Split
13	B-122	RUSSEL D.	11/28/01	11/28/01	11/28/01	$0.00	$1,545.80	1,563.80	$432.40	1,340.00	1,340.00	432.40	*11/01-04/02* *1,340.00*	$0.00	MC	Split
14	B-129	CARALYN D.	08/04/03	08/04/03	08/04/03	$0.00	$1,379.95	507.20	$311.87	607.20	507.20	311.87	*08/03-01/04* *1,284.00*	$0.00	MC	Used
15	B-163	LANCE	10/31/02	10/31/02	10/31/02	$0.00	$1,391.10	1,391.10	$563.39	538.03	538.03	538.03	*09/02-02/03* *1,564.00*	$25.36	MC	Split

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= claim not supported by the preponderance of the evidence															
16	B-164	RUDOLPH E.	06/02/01	06/06/01	06/05/01	$0.00	$4,342.00	5,000.00	$3,674.50	$1,722.00	1,722.00	1,722.00	06/01-11/01 1,718.00	$1,952.50	HO	Split
17	B-171	PATSY E.	08/31/04	08/31/04	08/31/04	$0.00	$952.55	952.55	$236.39	952.55	952.55	236.39	8/04 - 1/05 3,760.00	$0.00	HO	Used
18	B-175	PATSY E.	02/07/05	02/07/05	02/07/05	$0.00	$2,747.13	2,747.13	$652.97	1,958.30	1,958.30	652.97	02/05-07/05 3,316.20	$0.00	HO	Split
19	B-181	CONSUELO F.	10/22/02	10/26/02	10/22/02	$0.00	$7,897.65	8,812.40	$2,838.63	1,907.40	1,907.40	1,907.40	10/02-03/03 1,907.40	$931.23	HO	Split
20	B-182	STUART F.	04/08/05	04/09/05	04/08/05	$0.00	$11,357.50	11,357.50	$15,768.95	3,018.00	3,018.00	3,018.00	01/05-06/05 3,018.00	$12,750.95	HO	Split
21	B-200	LENA F.	02/26/02	02/26/02	02/06/02	$0.00	$1,337.05	1,337.05	$466.45	1,337.05	1,337.05	466.45	12/01-05/02 9,133.00	$0.00	HO	used
23	B-202	ROBERT F.	02/10/99	02/10/99	02/10/99	$0.00	$22,484.21	21,432.21	$24,157.88	2,430.00	2,430.00	2,430.00	02/99-07/99 2,430.00	$21,727.88	HO	Split
24	B-209	CAROL F.	10/28/03	10/28/03	10/28/03	$0.00	$2,664.25	2,664.25	$902.99	2,644.00	2,644.00	902.99	10/03-12/03 3,896.00	$0.00	HO	Split
25	B-214	CAROL F.	05/22/05	05/24/05	05/22/05	$0.00	$8,010.75	8,344.75	$3,840.86	3,660.00	3,660.00	3,660.00	04/05-09/05 3,660.00	$180.86	MC	Split
26	B-215	BRIAN F.	08/03/02	08/07/02	08/03/02	$0.00	$6,297.55	6,297.55	$2,242.60	1,188.00	1,188.00	1,188.00	08/02-01/03 1,188.00	$1,054.60	MC	Split
27	B-239	LEROY G.	09/27/04	09/29/04	09/27/04	$0.00	$6,448.20	3,607.43	$3,607.48	248.83	248.83	248.83	9/04 - 9/04 248.83	$3,358.65	MU	Split
28	B-256	FRANCINE H.	09/18/04	09/19/04	09/18/04	$0.00	$4,824.75	4,824.75	$3,111.47	1,632.00	1,632.00	1,632.00	09/04-02/05 1,632.00	$1,479.47	MC	Split
29	B-267	SHANNON H.	07/01/04	07/01/04	07/01/04	$0.00	$384.00	384.00	$61.60	384.00	384.00	61.60	07/04-12/04 3,948.00	$0.00	HO	Used
30	B-258		07/07/04	07/07/04	07/07/04	$0.00	$384.00	384.00	$61.60	384.00	384.00	61.60		$0.00	HO	Used
31	B-259		07/15/04	07/15/04	07/15/04	$0.00	$764.50	764.50	$73.16	764.50	764.50	73.16		$0.00	HO	Used
32	B-260		07/17/04	07/17/04	07/17/04	$0.00	$511.50	511.50	$73.16	511.50	511.50	73.16		$0.00	HO	Used
33	B-262		07/18/04	07/20/04	07/18/04	$0.00	$3,587.25	3,587.25	$1,556.07	1,620.00	1,620.00	1,620.00		$36.07	HO	Split

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= claim not supported by the preponderance of the evidence															
		NANCY H.										10/99-12/99			
34	B-263		10/10/99	10/10/99	$0.00	$382.25	382.25	$87.42	382.25	382.25	87.42	3,474.00	$0.00	HO	Used
		~~STEPHANIE H.~~										~~10/04-03/05~~			
~~36~~	~~B-285~~		~~11/28/04~~	~~11/28/04~~	~~$0.00~~	~~$301.25~~	~~201.25~~	~~$41.67~~	~~191.44~~	~~191.44~~	~~41.57~~	~~5,926.56~~	~~$0.00~~	~~MC~~	~~Split~~
~~37~~	~~B-288~~		~~02/07/05~~	~~02/10/05~~	~~02/07/05~~	~~$7,480.20~~	~~3,508.00~~	~~$3,238.36~~	~~3,508.00~~	~~3,508.00~~	~~3,238.36~~		~~$0.00~~	~~HO~~	~~Used~~
		~~LOWELL H.~~										~~8/99 – 8/99~~			
~~38~~	~~B-307~~		~~08/23/99~~	~~09/06/99~~	~~08/23/99~~	~~$55,760.15~~	~~900.00~~	~~$23,495.18~~	~~848.13~~	~~848.13~~	~~848.13~~	~~848.13~~	~~$22,647.05~~	~~HO~~	~~Split~~
		~~PAULETTE H.~~										~~10/03-03/04~~			
~~39~~	~~B-310~~		~~10/02/03~~	~~10/31/03~~	~~10/02/03~~	~~$13,158.00~~	~~13,158.00~~	~~$3,691.31~~	~~675.00~~	~~675.00~~	~~675.00~~	~~675.00~~	~~$3,016.31~~	~~HO~~	~~Split~~
												~~04/04-09/04~~			
~~40~~	~~B-318~~		~~03/02/04~~	~~03/31/04~~	~~03/02/04~~	~~$21,646.10~~	~~7,430.34~~	~~$6,087.99~~	~~180.00~~	~~180.00~~	~~180.00~~	~~180.00~~	~~$5,907.99~~	~~PB~~	~~Split~~
		JOHN H.										06/03-11/03			
41	B-358		06/18/03	06/18/03	06/18/03	$0.00	$800.25	800.25	$112.16	767.00	767.00	112.16	942.00	$0.00	MC	Split
		RICHARD K.										08/00-10/00			
43	B-394		09/20/00	10/02/00	09/20/00	$0.00	$17,267.50	17,267.50	$12,667.79	2,337.78	2,337.78	2,337.78	2,337.78	$10,330.01	HO	Split
		TATYANA K.										5/03-6/03			
44	B-404		05/24/03	05/24/03	05/24/03	$0.00	$1,350.75	1,350.75	$293.27	1,350.75	1,350.75	293.27	1,706.00	$0.00	HO	used
		SANDRA L.										11/00-04/01			
45	B-407		02/15/01	02/19/01	02/15/01	$0.00	$6,371.00	6,371.00	$3,840.86	767.00	767.00	767.00	767.00	$3,073.86	HO	Split
		JAMES M.										11/99-04/00			
47	B-449		12/13/99	12/13/99	12/13/99	$0.00	$548.50	548.50	$162.79	548.50	548.50	162.79	832.00	$0.00	HO	Used
48	B-450		01/15/00	01/15/00	01/15/00	$0.00	$791.25	791.25	$248.12	283.50	283.50	248.12		$0.00	HO	Split
		~~JAMES M.~~										~~11/00-04/01~~			
~~49~~	~~B-451~~		~~11/04/00~~	~~11/04/00~~	~~11/04/00~~	~~$0.00~~	~~$1,217.00~~	~~1,217.00~~	~~$344.71~~	~~948.00~~	~~948.00~~	~~344.71~~	~~880.00~~	~~$0.00~~	~~MC~~	~~Split~~
		~~DANIEL M.~~										~~09/03-02/04~~			
~~50~~	~~B-454~~		~~09/23/03~~	~~09/28/03~~	~~09/28/03~~	~~$0.00~~	~~$10,941.25~~	~~13,741.83~~	~~$13,741.70~~	~~3,612.00~~	~~3,612.00~~	~~3,612.00~~	~~3,637.00~~	~~$10,129.70~~	~~HO~~	~~Split~~
		~~MICHAEL M.~~										~~11/99 – 11/99~~			
~~51~~	~~B-467~~		~~11/03/99~~	~~11/05/99~~	~~11/03/99~~	~~$0.00~~	~~$6,558.05~~	~~6,558.05~~	~~$2,645.51~~	~~2,359.06~~	~~2,359.06~~	~~2,359.06~~	~~2,359.06~~	~~$286.45~~	~~HO~~	~~Split~~
		R. HENRY M.										04/03-09/03			
52	B-470		04/13/03	04/18/03	04/13/03	$0.00	$19,943.80	7,145.67	$7,145.56	2,900.00	2,900.00	2,900.00	2,900.00	$4,245.56	HO	Split

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[redacted] = claim not supported by the preponderance of the evidence															
53	B-476	SANDRA M.	11/20/04	11/20/04	$0.00	$105.00	105.00	$70.92	88.00	88.00	70.92	11/04-04/05 235.00	$0.00	MC	Split
54	B-478	RONALD M.	03/19/04	03/21/04	$0.00	$8,994.45	9,114.95	$4,525.68	1,574.00	1,574.00	1,574.00	02/04-07/04 1,574.00	$2,951.68	HO	Split
55	B-482	PHYLLIS M.	04/27/99	04/28/99	$0.00	$2,795.75	2,795.75	$4,137.65	1,087.90	1,087.90	1,087.90	11/98-04/99 1,087.90	$3,049.75	MU	Split
56	B-483	PHYLLIS M.	06/21/99	06/21/99	$0.00	$1,519.50	1,519.50	$393.44	883.50	883.50	393.44	05/99-10/99 1,107.00	$0.00	MC	Split
57	B-491	MARLENE N.	01/27/03	01/28/03	$0.00	$6,370.35	4,531.59	$4,531.46	3,029.54	3,029.54	3,029.54	01/02-06/03 3,029.54	$1,501.92	HO	Split
58	B-501	MARLENE N.	07/28/03	07/28/03	$0.00	$482.00	482.00	$69.84	449.50	449.50	69.84	07/03-12/03 2,932.00	$0.00	MC	Split
59	B-522	MARY N.	01/03/05	01/03/05	$0.00	$2,393.00	2,393.00	$484.60	2,008.00	2,008.00	484.60	01/05-06/05 2,008.00	$0.00	HO	Split
60	B-525	ROBERT N.	10/11/01	10/11/01	$0.00	$2,894.90	2,894.90	$932.65	2,004.00	2,004.00	932.65	10/01-12/01 2,004.00	$0.00	HO	Split
61	B-527	PATRICIA N.	02/18/02	02/19/02	$0.00	$12,050.45	8,642.65	$7,145.56	6,842.00	6,842.00	6,842.00	02/02-07/02 8,190.00	$1,303.56	HO	Split
62	B-530	BARBARA O.	10/22/99	10/22/99	$0.00	$758.50	758.50	$147.59	758.50	758.50	147.59	8/99-10/99 837.00	$0.00	HO	Used
63	B-540	DAVID P.	08/27/99	09/06/99	$0.00	$11,980.25	11,980.25	$7,342.93	1,367.20	1,367.20	1,367.20	06/99-11/99 867.20	$5,975.73	HO	Split
64	B-546	JACK P.	08/28/01	08/28/01	$0.00	$1,557.75	1,557.75	$513.94	1,557.75	1,557.75	513.94	07/01-12/01 2,241.50	$0.00	HO	Used
66	B-554	LONNIE P.	08/20/02	08/20/02	$0.00	$900.00	900.00	$319.57	900.00	900.00	319.57	08/02-01/03 1,813.00	$0.00	HO	Used
67	B-555	VERNICE D.	12/31/02	01/02/03	$1,300.00	$7,866.75	8,322.30	$1,811.47	1,380.00	1,380.00	80.00	10/02-03/03 1,380.00	$1,731.47	HO	Split
68	B-558	PATRICIA Q.	04/26/01	04/26/01	$0.00	$11,629.00	2,548.00	$5,238.03	2,548.00	2,548.00	2,548.00	04/01-09/01 3,885.00	$2,690.03	MC	Used

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69	B-566	PATRICIA Q.	10/04/01	10/04/01	$0.00	$16,820.90	5,424.00	$7,685.99	3,879.00	3,879.00	3,879.00	10/01-3/02 3,816.00	$3,806.99	HO	Split
70	B-570	THOMAS R.	01/13/99	01/20/99	$0.00	$10,220.25	10,220.25	$11,000.78	1,864.33	1,864.33	1,864.33	11/98-04/99 1,864.43	$9,136.45	HO	Split
71	B-586	JONATHAN R.	03/08/02	03/08/02	$0.00	$26,985.08	26,985.08	$11,468.67	919.00	919.00	919.00	02/02-07/02 919.00	$10,549.67	HO	Split
72	B-593	DIXIE R.	10/21/00	10/24/00	$0.00	$6,623.50	5,443.00	$6,695.74	2,206.50	2,206.50	2,206.50	08/00-01/01 2,216.50	$4,489.24	HO	Split
73	B-599	RICHARD S.	12/24/04	12/29/04	$0.00	$11,645.55	5,317.81	$5,317.67	4,823.29	4,823.29	4,823.29	12/04-05/05 5,720.00	$494.38	HO	Split
74	B-612	RICHARD S.	05/26/04	05/28/04	$0.00	$7,860.55	8,079.55	$4,750.21	8,079.55	8,079.55	4,750.21	05/04-10/04 0.00	$0.00	HO	Used
75	B-635	SANDRA S.	11/23/04	11/25/04	$0.00	$34,279.02	40,058.57	$6,182.55	573.00	573.00	573.00	09/04-11/04 573.00	$5,609.55	HO	Split
76	B-645	ORELLA S.	11/09/02	11/10/02	$3,134.61	$6,608.00	6,646.00	$1,356.71	5,289.13	5,289.13	1,356.71	11/02-04/03 6,976.74	$0.00	MC	Split
77	B-683	JODY W.	06/05/01	06/05/01	$0.00	$403.75	403.75	$60.46	156.00	156.00	60.46	06/01-11/01 156.00	$0.00	HO	Split
78	B-706	CYNTHIA W.	01/01/05	01/04/05	$0.00	$7,169.00	7,169.00	$3,238.36	3,370.37	3,370.37	3,238.36	09/04-02/05 3,537.12	$0.00	HO	Split

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